CPHE

Initiatives

Issue No.1

in Community Action for Health

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Q94

What about health for all?

Developing responsible leaders for health systems

Gender for equity not equality

A Publication of Afri-CAN • April 1998

The African Community Action Network for Health (Afri-CAN)

Offers:—

- Platform for the devepment and support of Community Based Health Care (CBHC) in the South
- Focused response and contribution to global trends, agenda and policies.
- Organised and united contribution in the South to current policy processes in health(such as health sector reform, privitisation etc)

It further:—

- Promotes linkages and exchanges with other continents.
- Aims at strengthening agencies invloved in CBHC so as to effectively address the issue of equity to meet the basic needs of the most marginalised groups -- women, children, and young people.

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Initiatives is published quarterly in English and French by African Community Action Network for Health (Afri-CAN). It aims at projecting individual and collective initiatives towards a Continental Community Health Strategy

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Cover
Sense of community starts at a tender age.
Picture by Lucas Owuor - Omondi

Why another 'new' magazine

Dr. Dan Kaseje

The world is choked with magazines and newsletters. We certainly do not wish to add yet 'another' publication to these. However, we believe that *Initiatives* will be different in that it will be a publication which can be truly supportive to all stakeholders involved in sustainable Community Based Health Care (CBHC). It also intends to facilitate the establishment of a global communication mechanism with a platform in Africa, for mutual nourishment, and development in the fields of Community Based Social Action for Health. This is necessary to maximise the effectiveness of individual and collective contribution to the improvement of the situation of the most disadvantaged individuals, families and communities, in partnership with them. The magazine will focus on the CBHC as an approach to Health Care towards Health For ALL in the 21st century.

Several models of interventions and innovations built around indigenous efforts, and assets have been developed. Most of these models are suited to the front-line community-based agencies, like your own, who have a vision, a mission and a commitment to pursue the struggle for social justice. Some of these interventions have generated positive results for local communities where solutions to most health and development challenges must be sought.

However, the potential to communicate the processes, progress and impact of these community based experiences with and among concerned individuals as well as within Africa and beyond needs to be harnessed in order to generate sufficient evidence of replication as opposed to scaling up.

The responsibility of moving these gains towards the necessary continent-wide transformation in health and well-being at all levels is more urgent now than ever before. This requires a world wide coalition of concerned partners like yourselves. The reason being that community members, individuals and agencies involved in health and development need to be encouraged to provide the necessary support and leadership in the development and implementation of Community Action in which they have strategic advantage, experience and competence.

In this regard, an important task of Afri-CAN is to facilitate the documentation and sharing of information on existing practical experiences and make examples available for public awareness, while ensuring back up to community efforts. We are concerned that the voice of the grassroot groups and individuals ought to be heard in the process and we must ensure that their contributions are included in this respect. It is our understanding that producing a magazine of this nature is not an end in itself. The process requires providing an objective framework for monitoring and measuring success in order to share it. In this regard, beyond the production and dissemination of *Initiatives,* we intend to use documented data for effective negotiation and advocacy for national and international support towards equity in health care. This underlines the importance of *Initiatives.*

There is no issue in health and community development we will shy away from covering. The difference we aim to make is the manner in which we cover it. I am therefore delighted to present to you *Initiatives* — a publication rich in human experience, balance and informative — a publication which while upholding high journalistic values recognizes that humans come first and journalism second.

Dr Dan Kaseje
General Secretary - Afri-CAN

"COMMUNITY HEALTH WORKERS SHOULD PROTECT POPULATIONS FROM 'SAFARI' RESEARCHERS".

"Safari" research has become booming business

"Safari" research is a growing and lucrative industry. All it requires of a foreign medical researcher is the use of a local contact in Africa to gain access to a population group in order to obtain samples for analysis in home laboratories.

The results do not have to be made available to the host African country. The investment is low and the returns often high and rewarding. It is also dubbed as "helicopter" research.

Testing drugs in Africa is considered cheaper for many reasons. Due to low standards of health care or lack of health care altogether, risky and unproven therapy goes with less objection. Many a time risky experiments are accepted as better than nil health care and therefore easy to persuade the sick to enrol for clinical trials. Ironically too, the impact of colonial legacy helps the intrusion . It is a silent exploitation of Africa.

Accordingly, it is feared that as AIDS experimental therapies and vaccines become available, there will be a growing pressure to test them in Africa. Currently, there are over 600 AIDS related studies underway in Africa, most by foreign researchers and about half of them are not known to national AIDS control bodies.

Research, irrespective of the sponsor, should be aimed at meeting the needs of a host country. Equally so, it is not fair to test drugs or vaccines in countries which will not be able to afford them when they are later marketed.

Community based health workers have some exacting tasks here towards ensuring the protection of research subjects, observance of ethical values as well as ensuring informed consent. Their responsibilities could include drawing the attention of the relevant national bodies so that the needs of a host country and not only of the sponsor, are addressed.

Mitch Odero

Letters

Congratulations for launching Initiatives

Editor,
I write to congratulate you for the production of the first edition of *Initiatives*. This publication will indeed fill in a gap in the area of documentation of experiences, ideas and developments in the field of health. Due to the fact that we in Africa do not have the culture of reading and writing , a good deal of vital information in this field is often lost for lack of documentation.

Meanwhile, the health situation of the continent demands that experiences, ideas and developments in health are shared all over, to encourage those working in this area as well as help ameliorate the living conditions of the populations, not only of those in the low income group, but the whole of society.

The time has come for real initiatives to be taken by the people who are in the favourable situation, instead of waiting for outsiders to dictate to them what they must do to improve their health and living conditions in general.

On my part, I shall endeavour to contribute articles on health issues in my country Ghana, and the West African sub-region, and also collect and forward to you appropriate articles for publication in *Initiatives*.

Let me wish you and your staff the very best in your work and all of God's blessings as you continue this good work.
Mina Ansa
Accra, Ghana.

Editor,
I am very happy to hear that the process for the Network Publication is starting to happen.
Gabriel Urgoiti
Director, NPPHCN Media and
Training Centre
Cape Town, South Africa

Editor,
I am very happy that a new magazine on community-based health and development is born.
Diana Smith
Editor of Contact
World Council of Churches-CMC
Churches Action for Health
Geneva, Switzerland

Editor,
The birth of 'Initiatives' is good news for us in Central Africa, particularly because it will be published in both French and English.
Father Vata Diambanza
Director, Africa Documentation,
and Information Agency
Kinshasa/Gombe
D.R Congo

Editor,
Your letter of 10th February brought news of exciting development in Afri-CAN, particularly in the area of publications. I do wish you success with *Initiatives* in Community Action for Health and I hope that the communities that have been set up will strengthen your capacity to share information and stimulate new development in health.
Rev. Ana Langerak
Executive Director,
Programme Unit II
Churches in Mission:
Health, Education, Witness
World Council of Churches.

Drugs price tags

Editor,
Congratulations for publishing Afri-CAN / magazine. I have been reading many newsletters, some of which touch on the problems of donated drugs to church/ health institutions. Will you in one of future editions focus on issues related to costing of these donated drugs including those used beneficially and those expired before use ?
Blasio Mujungu
CSSC
Dar-Es-Salaam
Tanzania

Set to announce

Editor,
We will be glad to announce the birth of Initiatives in the next edition of our bulletin.
Editor of the French version,
Africa News Agency (AANA)

Tool for empowerment and for life and light

Editor,
I certainly pray and hope that what Afri-CAN will produce by way of Magazine will be a tool for empowering our people in the urban and rural areas, to make better choices for their lives.

AACC has *tam tam*. Its circulation is limited, even with the Churches. But we can surely do more together when Afri-CAN newsletter can echo some of the issues *tam tam* is putting across and vice versa; the aim being service to our people, bringing life and light to our people.

Rev. Canon Clement Janda
Secretary General,
AACC, Nairobi
Kenya.

On the right target

Editor,
You could not have chosen a more appropriate name for your magazine. By sharing ideas on Community
Based Health Care, *Initiatives* will reach and awaken even those in other disciplines to realise that even they can contribute in the *health for all* goal. *Initiatives* will therefore also "initiate" interest and a realisation in other related and non-related fields not necessarily for active involvement in health issues but for individual advocacy. You are right on target for the accomplishment of your goal - getting *everyone* involved in the real sense in *community Action for Health.* My strongest support and encouragement!
Elizabeth Dena
Pharmaceutical Programme of
WCC/CISS

Looking foward

Editor,
I look forward to receive the first issue of Initiatives.
Dr Frits van der Hoeven
Medical Coordination Secretariat
Oegstgeest, Holland

No one can lead without clearly knowing the direction

Editor,
There is no leadership without a vision. No one can lead unless they have an idea of where they want to go, and no one wants to follow for long unless they see themselves as beneficiaries. Yes a vision has to deal with future.

I take this opportunity to thank all those men and women (particularly Dr. Dan Kaseje) who have taken the initiative of sharing their vision with the other participants of a training workshop on publication for Health Action for a better future - health and development.

It is my prayer and wish that all the participants will be visionary leaders in:

(a) empowering the community to:

• build confidence in themselves and use the available resources,

• share their diversified cultural, social, economic and political experiences to solve the current problems,

• find our publication, *Initiatives* 'their own'.

• sharing ideas and experiences that will be used by health actors to work out solutions and build up training materials

• transforming the continent of Africa from being a 'nest' of common health problems (malaria, HIV/AIDS) and political unrest, into a self-reliant continent.

May God bless each participant to become an effective 'salt of the earth and light of the world' in contributing to the success of *Initiatives.*

Jonathan M. Kiliko
Training Manager, MEDS
Nairobi, Kenya.

Time to celebrate. Election of officials of Kaibor Women's Group, Turkana, Kenya during a strategic planning workshop

Cultural dislocation cause us a loss

Editor,
I appreciate the launching of *Initiatives.* I live in a country where Traditional Birth Attendants (TBAs) have been crossed out of the agenda because the policy makers wanted to develop modern schools for nurses. At this time of political changes, I wish you would address this issue seriously.

Traditionally, pharmacology is improving indeed, but it is still facing opposition from some churches whose doctrines don't seem to distinguish between the message of the gospel and the colonial cultural dislocations.

Africa is rich, a fact many may not appreciate. It is therefore hoped that *Initiatives* will project community initiatives than sole reliance on expert theories and conference reports.

I wish *Initiatives* success and look forward to reading the first issue.

Polisi Kivava.
D. R. Congo

Glad for this step

Editor,
I should like to congratulate you for launching the *Initiative* in Community Action for Health.

We are glad that you took this step and we wish you, your colleagues and the start of the new publication God's guidance and his blessing.

Rainward Bastian
Director,
DIFAM
German Institute for
Medical Mission
Germany.

You inflamed my desire to be a writer

Editor,
I wish to congratulate Afri-CAN and the Pharmaceutical Programme for organising a training workshop for budding writers like me, from different regions within and outside Kenya in February this year.

Your mix of diverse experiences and views from participants inflamed my desire to be a writer specialising in health and development.

It is with this encouragement that I look forward to becoming a regular contributor of articles to the *Initiatives* magazine.

At long last, our communities now have an alternative forum for sharing their experiences, fears, or otherwise, in your newly launched magazine published by Afri-CAN.

Kindly include me in your future workshops as well as the mailing list of *Initiatives.*

Paul Mbanga
CISS,Kenya.

Developing a health system that is supportive at the community level

By Dr. Miriam K. Were

In 1978, International Conference of Primary Health Care made the case for the community level that still stands. Among the benefits were the following:

(a)If one involves communities, one is likely to get to and deal with the source of the problem in a majority of cases.Instead of simply keeping busy wiping the floor while the tap continues to leak, you look for ways to turn off the tap.It is no wonder that the bulk of community based health care activities are in the areas of promoting health and preventing disease.And even in the 1990s and into the next millennium, prevention is still better than cure!(b)If one involves the community, one is more likely to build on positive elements of preexisting life styles in the community, which enhances the chances of having a viable health care approach that is socially and psychologically relevant and acceptable to the people.

There are numerous studies which show that people often go past hospitals to a traditional healer far away.It used to be thought that this was because people were too primitive to know what was good for them.But now we know it is because managers of health care approaches have been too ignorant to plan health care services that are socially and psychologically relevant and acceptable by people and usable for whom they are planned.

The community as the Bedrock of the Human Relationship

It is often pointed out to me that the community context must fade away as the price for development.Those who hold this view do not give instances where communities in currently industrialised countries received the attention they needed to help them evolve as viable entities as these societies developed.Maybe this attention was not given because the hazards from the absence of a sense of community were not understood.Now we know that the price of the absence of a sense of community is high as it removes the natural fabric in which the individual is affirmed,

Dr. Miriam K. Were

recognised as a member and in which a social support network is provided.The result has been life in a state of alienation that hinders many individuals in industrialised societies from enjoying their material progress.This is probably the contributing factor in the symptoms of alienation that are becoming evident in industrialised countries such as systematic serial murders and deliberate release of poisonous gases into trains with innocent travellers which express extreme states of alienation.With these negative consequences of the breakdown of community clear to us, Africa need not repeat the same process of alienating individuals in a communityless existence.On the other hand, change is the reality of existence and trying to make community parameters stay the same forever and ever is not a viable option.What is needed is insight and vision to help the community evolve in the reality of the changing circumstances so that a sense of community can be maintained even in the midst of chances.This evolution may need rearrangements such as what tasks are to be carried out by which members of society in the interest of community cohesion while also taking note of the realities of the democratic trends and matters of gender parity.Some argue, and I am among them, that the stillviable community context in Africa, gives Africa a chance for the possibility to develop without paying the price of the alienation of the individuals.Africa has an opportunity to graft technological development into the matrix of the existing network of human relationship within communities whose caring capacity can be enhanced.If while developing, Africa can retain this community context, Africa would have reason to be proud of itself.The community constitutes the bedrock from which most other realities emerge and the reality of the community is larger than the sum of its parts.CommunityBased Health Care (CBHC) is one of the most viable approaches of building on this community context.

ENABLING ENVIRONMENT FOR COMMUNITY BASED HEALTH CARE (CBHC)

If communities could solve their problems spontaneously, they would be doing it and we would only report success.The fact of the matter is that communities are having a tough time.With the unfair terms of trade on the international market, many are growing more quantities of cotton, tea, and coffee and getting less money for the fruit of their labours.Others are mining greater quantities of copper and still earning less.The proportion of those living in poverty is increasing in many developing countries.The level of despair and frustration in many communities is very high because these communities are impinged upon by the realities of living in an information/electronic wave as members of the global village, even though the realities of their existence still places them in the preindustrial era of subsistence farming.The level of frustration is rising because many in these communities know what is happening elsewhere from the information getting to them and this makes them realise how deprived they are.The impact of HIV/AIDS pandemic at the local level is not making matters any easier in addition to everything else.The state of desperation and apathy depends.So the need

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What about health for all

Definition

Health for All is the goal of the world community to provide universal access to Health Care resources in order to attain an economically productive level of health.

Child growth monitoring session in south Gem (Kenya) CBHC project

Origins

The concept and vision of *Health for All* were defined in 1977, when the Thirtieth World Health Assembly decided that the main social target of governments and World Health Organisation in the coming decades should be "the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life."

Consequently, the declaration of Alma-Ata, adopted the next year, 1978, by the international conference on Primary Health Care on the sponsorship of WHO and UNICEF stated that Primary Health Care was the key to attaining Health for All as part of the overall development.

The WHO document titled "*Health for All in the 21st Century*" says the crusade was conceived as a process leading to improvement in the health of people and not as single finite target.

According to the document, HFA can vary in interpretation depending on the social, economic and health characteristics of each country. However, it is acknowledged that there is a baseline below which no individuals health in any country should fall.

The way Ahead

The renewal of commitment to Health for All in the 21st Century is a welcome news for those of us who were permanently committed to the goal. It is indeed necessary to continue building on past achievements, guiding action and policy for health at international, regional, national and local levels. The renewed commitment encourages efforts to identify global priorities and expects substantial gains in the first two decades of the 21st Century.

Progress

During the last two decades, governments and NGOs have increasingly accepted HFA as their goal in their efforts to

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Policy oriented monitoring of equity in health

The council for International Organisations of Medical Sciences/World Health Organisation conference during March 1997 discussed different concepts of equity under the title 'Policy-Oriented Monitoring of Equity in Health and Health Care.

In his presentation, Prof. Robert M Veatch of Georgetown University considered whether equity and utility were complementary or contradictory.

The author notes that while public health has shifted the focus of medicine from the individual to the society, most practitioners of public health have retained the commitment to maximizing of health outcomes as a moral imperative.

On the other hand, Veatch says that *equity* is a concept related to the world principle of justice in a manner similar to the relation of efficiency to the principle of utility. *Equity,* he adds, focuses on fairness in the pattern of distribution of well-being.

In discussing *Health for All*, the author stresses the need to distinguish between aggregate measures and distributive measures. *Health for All*, he says, calls for more attention to distribute measures even if aggregate measures are sacrificed in the process.

In another presentation, Norman Daniels of the Department of Philosophy at Tufts University, reviews ethics and health care reforms.

According to Daniels, health care, by promoting normal functioning, makes an important, if limited, contribution to assuring equality of opportunity. This, he adds, gives an explanation of its special, though not unique, moral importance.

The author says this equal opportunity account of the justice and health care has important implications for the design of health care systems, including for access, for types of services and for financing.

In evaluating the ethical impact of health care market reforms, the author discusses the case of the health care reform in the

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NGOs—role, experience, strengths and hiccupps

It is acknowledged that the Non–Governmental Organisations portray great diversity within countries. In fact, the impact of NGOs vary depending on the area of operation, their size and other factors that justify their existence.

This paper focuses on formal, legally constituted non profit agencies with corporate objectives "but not sponsored, governed or funded by the state, yet working within the laws established by the state."

Since Africa has lagged backwards when other hitherto poor regions of the world have prospered, it is imperative that all concerned agencies – state or non state – must be involved in order to make a difference in health care and well–being.

The majority of NGOs work at local areas with activities which include service provision, research, networking and policy advocacy. The range of health service activities provided by NGOs stretch from primary to tertiary levels.

According to the paper, the on–going health sector reform in most African countries focus on "conceptual and practical separation of critical components of the health sector such as policy development, funding, delivery of services as well as regulation of quality, on the other."

"...NGOs are better placed to develop and manage effective sustainable holistic programmes. The consequent policy shift away from the sophisticated urban–based services towards basic prevention oriented care demands intensification of the involvement of NGOs since they are more experienced in those domains".

Although African countries may differ in terms of social, cultural and political setting, the basic public health problems such as lack of clean water, poor sanitation and waste disposal systems remain the same.

The paper suggests that independent government initiatives are inadequate for the attainment of the global goal of *Health for All.*

In recent times, the paper adds, financial support for the NGOs has increased. The authors say increased emphasis has been placed in the development of National NGOs to participate effectively in addressing local health and development problems.

The paper cites several constraints facing NGOs saying many are "merely conduits of humanitarian relief or implementing agents for international agencies." But they note that contracting with government for activities in which particular NGOs have comparative advantage must be explored to service their financial base for the benefit of all stakeholders.

Many National NGOs would benefit from a programme of institutional strengthening for NGOs in the Health Sector to ensure that they have appropriate capacity for the functions they undertake within a sound governing and management framework.

Ensuring equity or equality?

Equity implies fairness in the patterns of the distribution of and accessibility to services of well–being. Monitoring of equity in health and Health for All should be the basis for policy analysis and formulation. They should be based on a policy framework as well as health outcomes notably,

- essential elements of livelihood (EEDL)
- health status
- community–based / society based

The focus is not in maximising the aggregate but in targeting on the situation of the poorest section of the society. 'Hence, aggregate measures and distributive measures must be considered with maximum focus on the distributive measures' (Robert M. Veatch).

Assurance of equity is different from equality of opportunity. It does not mean giving everybody same services. Therefore the policy on health sector reform emphasizing privatization, market mechanisms, decentralisation is contradictory to health for all emphasis.

Core messages

- What is a well–functioning NGO that can make meaningful contribution and address issues of diversity
- What are the range and level of NGOs in Health and Health care? The greatest strength is at community level. Creates impact in great number of people

What comparative advantage do they have vis–a–vis the state in the context of shift towards market paradigm?

- Do NGOs regulate market forces in favour of the poor?
- Do they provides alternatives for the poor in the context of emphasis shift to privatization.

Constraints

Precariousness of funding

Increasing cost of services and as well as reducing subsidies could marginalize their target

How to strengthen NGOs for more effectiveness

Quest for alternative sources of funding. For example contracting is of comparative advantage. ❍

Give us peace not dispensaries

The aspired "Health for All" in the 21st Century is seen as a mockery particularly in the African countries locked in civil wars.

During a survey by Initiatives, peace was found to be of a higher priority in the minds of many.

A resident of Kigali, Rwanda summed it up bluntly, "we have skeletons left all over, of thousands upon thousands of our dear ones who can no longer share that aspiration, you better give us peace first not dispensaries, our skeletons do not need clinics"

Realising the vision of Health for All challenge

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improve health. Most countries have adopted Primary Health Care.

According to WHO, access to the elements of Primary Health Care, as defined at Alma-Ata, has steadily increased despite wide variations both within populations and between countries.

In fact, Primary Health Care, together with economic, educational and technological advances, has contributed significantly to the worldwide decline in infant child mortality and morbidity and to the substantial increases in life expectancy at birth.

Despite these health gains, progress has been hampered by several factors. Evaluation of the 1979-

1996 period shows that in many countries, progress towards HFA has been hampered by the following:

- a lack of political commitment to the implementation of HFA
- failure to achieve equity in access to all PHC elements
- the continuing low status of women
- slow socio-economic development
- difficulty in achieving intersectoral action for health
- unbalanced distribution of, and weak support for, human resources
- widespread inadequacy of health promotion activities
- weak health information systems
- pollution, poor food safety, and lack of safe water supply and sanitation
- rapid demographic and epidemiological changes
- inappropriate use of, and allocation for, high-cost technology
- natural and man-made disasters

The above factors were outlined following the major evaluations of the Global Strategy for *Health for All.* It has also to be noted that a lack of health policy and management has impeded progress. And health services are paying the price for certain economic policies.

For all the gains and constraints to the HFA process, there are new trends that would influence health in the 21st century. These include;

- widespread absolute and relative poverty
- demographic changes: aging and the growth of cities
- epidemiological changes: continuing high incidence of infectious diseases; increasing incidence of non-communicable diseases, injuries and violence.
- global environmental threats to human survival
- new technologies: information and telemedicine services

In considering new bases for action, it becomes clear that a key aspect will be the strengthening of the participation of all people. The HFA vision recognises the oneness of humanity and is based on the following key values;

- recognition that the enjoyment of the highest attainable standard of health is a fundamental human right;
- ethics: continued and strengthened application of ethics to health policy, research and service provision;

Mothers attending a nutrition counselling session in South Gem, Kenya

- advances in biotechnology
- evolving partnerships for health that include the private and public sectors and civil society
- globalisation of trade, travel and the spread of values and ideas

Goals

The WHO, the broad goals of HFA can be realised through strengthened support for key values including human rights, equity, ethics and gender sensitivity.

- equity: implementation of equity-oriented policies and strategies that emphasise solidarity, and
- gender sensitivity: incorporation of a gender perspective into health policies and strategies.

The role of WHO

WHO has outlined global HFA targets to the year 2020 in the areas of health outcomes, intersectoral action on the de-

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Dynamic leadership required for progress

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terminants of health and health policies and systems.

Because WHO has the mandate and the responsibility to guide other partners involved in global governance of health towards attainment of HFA, it has to focus its functions and role to such challenges during the 21st Century.

WHO will, above all, serve as the world's health conscience by providing leadership and advocating HFA. The organisation will also develop global ethical and scientific norms and standards amongst other pressing responsibilities.

Realising the vision

In fulfilling the objectives of HFA, strategic lines of action must be taken to address the determinants of health and to make health central to human development.

The actions must aim to:

- combat poverty,
- promote health in all settings,
- align sectoral policies for health,
- include health in sustainable development planning.

The key to successful implementation of HFA in the 21st Century has to be based in the realisation that progress from policy to action requires dynamic leadership, a sense of direction and resources.

According to WHO, governments need to have a strong policy-making capacity to address the challenges ahead. Indeed governance is the system through which society organises and manages the affairs of diverse sectors and partners in order to achieve its goals.

It is one thing to set priorities for action but it is imperative that priorities should be set using an open, consultative approach involving the public and key partners for health.

Admittedly, the current initiative into the 21st Century is not new. It represents a drastic revision of the vision of the past 20 years. While it is encouraging for those of us who were permanently committed to the Health for All goal beyond the year 2000, it is hard to avoid cynicism as to whether the renewed commitment will be sustained or whether it will be more effective than the Alma Ata package. The current global trends make it imperative to be more careful in committing ourselves to the Health for All goals without adequately addressing:

- The apparent receding role of the state in Health and Health Care and capacity to control the factors that have profound influence on health status.
- The global shift to the right, promoting the privatization of health services without adequate alternatives for the poor and the vulnerable.
- The current and increasing violence, conflicts and insecurity affecting many countries of the world, particularly so in Africa. Is Health for All possible without peace for all?
- Is it possible to define the highest level of health to permit more scientific assessment of the monitoring of the implementation of the new commitment? Is health status a commodity to be delivered or an attitude and state to be acquired?
- Is the scanty reference to community's role in Health for all a departure from the previous view that Health for All is not attainable without the active participation of individuals, families and communities in addressing their health needs using their own resources?
- The renewal statement, like the Alma Ata Declaration is full of adjectives with few active verbs. What are the main actions that could be taken at various levels to ensure progress? Otherwise what is new in the renewed commitment? Will the policy rhetoric be followed by practical implementation guidelines?
- What follow-up mechanisms will be put in place to ensure implementation and monitoring?
- Are human resource development and training programmes relevant to the vision? What mechanisms have been put in place to address the adjustment of training curricula and programs that would ensure the development of skills relevant to the renewed initiative?
- What strategies will address the factors that undermined the implementation of the Alma Ata Declaration, namely:

Inadequate political commitment
Under-funding
Rapid demographic and epidemiological changes
Man-made and natural disasters
Increase in poverty
Globalization of communication and of trade, which are sure to marginalise the most vulnerable

- Political instability, conflict, violence and war.

To name but a few of the factors.

All concerned stakeholders must reflect seriously on the above questions in order to forge ahead towards the health for All goal.

This article presents highlights of WHO document, Health for All in the 21st Century, which has since been passed by the governing council. ❍

Issues of policy

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United States as well as market reforms in selected European experiences.

Daniels submits that although there are significant motivations for emphasising the importance of a private sector and market mechanisms as a component of health care reforms in developing countries, they seem to "lead us to a contradiction"

The CIOMS/WHO concern about equity in health care reform, he adds, strengthens the case for a research project aimed at modifying and extending the benchmarks of fairness methodology for use in monitoring ongoing health care reforms. ❍

A new initiative in Africa focuses on the need to develop a charismatic and democratic leadership in community based health care. Dan Kaseje, General Secretary, Afri-CAN, talks about the vision for the Afri-CAN for Health Network in an interview.

The vision driving Afri-CAN for Health Network

By Isobel McConnan

Q. What inspired the birth of Afri-CAN and how does it relate to existing health care particularly in rural Africa?

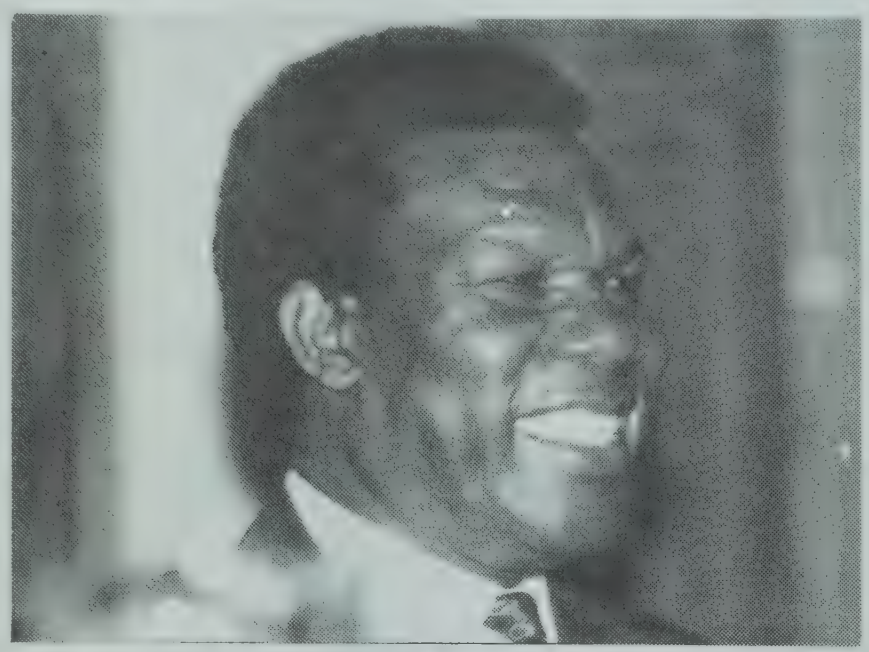
A. Church organisations currently provide more than 50% of health care services in Africa. In several countries such as Democratic Republic of Congo, almost all health services are now run by church providers, both in the hospital and community sectors. Where the church is not a ready alternative, in Somalia for example, the Red Crescent and International Federation of the Red crossare key providers. But for many poor countries in Africa - and indeed worldwide - affordable health care is beyond their reach.

Community based health care (CBHC), however continues to offer hope. Most poor communities in Africa depend on their own knowledge, skills and resources in order to stay alive and well. This is the basis for the development of CBHC and is the reason why it is most viable, if not the only, option for sustainable health care. But it must have back-up and a supportive environment.

Yet the diversity of experience in CBHC has ironically now become a weakness. Many activities are fragmented, isolated or go unrecognised. Health workers frequently lack information about other experiences or about existing resources. Importantly, there is as yet no system to provide logistical, moral and technical support such as training, or to develop human resources.

Q. What is the scope of Afri-CAN vision?

A. The World Council of Churches is among many church and secular organisations involved in health care in Africa now searching for ways to sustain and promote community-based health care. In October 1995 community health leaders and activists from 10 African countries, along with the IFRC and CMC-Churches Action for Health came together in Harare to pool ideas, renew their vision and decide a programme of action. It was here that a radical new initiative was launched: Afri-CAN - the African Community Action for Health Network.



Dr. Dan Kaseje sharing light moments during the first international CBHC conference in Nairobi, Kenya

"The person being empowered is also a recipient. This is a contradiction in terms"

Being a health professional with long experience in community-based health care and training in his own country Kenya, and in many other countries in Eastern, Southern and West Africa, I was a participant at the Harare consultation.

"Those of us working in community based health care have been confronted by a number of major difficulties. Firstly, international organisations are more and more preoccupied with emergency health issues and effort is being diverted from long-term community approaches.

"Secondly, the free market and profit-motivated private sector are gaining prominence in health. Alongside this, communities are feeling directly the effects of structural adjustment in the public and social sectors in education and health. Public sector health services can generally be said to have failed in Africa while the private sector has little to offer poor people. We feel that we have to offer a third option - one which will ensure adequate access to health care for those who cannot afford to pay. The so called 'safety nets' advocated by economists in the World Bank are just not safe enough.

Q. How would you sum up the objective of Afri-CAN?

A. The Afri-CAN Network will provide a mechanism for sustaining, promoting and sharing information about community-based health care across the continent of Africa. But the radical distinguishing feature of the network lies in its aim to develop a charismatic leadership within the CBHC movement. Community leaders haven't emerged because health is still dominated by medics, who are themselves not trained in leadership and management. There is also the problem that concepts of partnership and empowerment are defined by professionals. In other words, 'empowerment' is not 'do your own thing', it is 'do our thing'. For community leaders to evolve, there has to be a level playing field, so that partnership is truly equal. We also have to examine our language and attitudes - in aid terms, the person being 'empowered' is also a 'recipient'. This is a contradiction in terms.

The Afri-CAN Network provides a means of actively searching out and developing the potential of individuals working for health within their communities. This process must take place at all levels and at all ages and particularly within primary schools.

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Afri-CAN will provide the needed means

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Agencies and countries need to work together to identify and develop activities to give people the space to grow, and to become leaders in their own right.

A good example of a small Kenya-based organisation, Community Initiative Support Services (CISS) which works to identify the energies within communities, and facilitate activities to develop people's potential.

The conventional starting point of training is an analysis of people's deficiencies and needs, but CISS has found this approach to be fundamentally flawed. Instead, they have developed a range of activities which focus on identifying and expanding strengths and potential. Such is its success, that CISS is slowly expanding its activities to other countries on the continent and has some involvement beyond Africa.

Q. I understand you are setting up what you term as "anchor sites" could you explain?

A. "Practical steps are now being taken to ensure the success of the Afri-CAN concept. Of importance is the need to establish anchor sites": "We need to build on the unique potentials shaped by historical and recent experience that exist across Africa. Within East Africa. For example, there has been a long exposure to community-based development and training. In the struggle for political and social welfare, the countries of southern Africa have done more - they are strong in advocacy and negotiation and so on. West African countries have been confronted by political disruption and war and so have been developing ways of dealing with this. In identifying and recognising areas of activity we hope eventually to develop sites of excellence and to promote exchange and sharing of experience."

I expect many of these anchor sites to be located among church providers, who are taking the lead on community approaches to health care. NGOs and churches are, I believe, much better placed than governments to facilitate community-based health:

Q. To what extent is your confidence in the competence of the church as health care providers?

A. "When talking about the 'third option', church providers have a major role. They are providing care and attempting to recover costs, but without the profit motive. We have seen institutions providing demonstrably effective quality care which people can afford."

But church providers have yet more to offer. Health care is more than mere technology which on its own achieves nothing. I believe that church providers have a critical role in addressing the 'moral', ethical and human rights issues that are crucial to a holistic and equitable approach to health care." There are shortcomings though. They include poor leadership, governance and management as major concerns. In most churches, the chief executive heads are both governance (eg synods, boards of elders etc) and management functions (eg church administration, church facilities, programmes). This severely undermines accountability and compromises professional management and practice:

"The so called safety nets are just not safe enough"

"Leadership within the churches is almost always authoritarian and control is in the hands of a few - usually one only. I have seen how humble and effective leaders in the community become transformed when they move up the hierarchy. In Africa, this is a mirror image of what happens in government. There is a further problem that many are becoming involved in health care because they see this only as an avenue of evangelisation."

To counter this, Afri-CAN network would become active in developing an enlightened leadership within health care organisations and groups, through which to evolve truly democratic processes and accountability.

Q. You will no doubt need some enabling finacial resources at a time of donor fatique. Could you comment?

A. On the question of financial resources, if the word -of mouth reponse is anything to go by, and we have had a lot of encouragement, I think the seed money would be available to get the network going.

Critical to the success of the Network will be its ability to develop alliances and mobilise support across the board. We need all groups to support the vision of CBHC so as to create an enabling environment for the movement to work.

This vision demands action and solidarity based on a commitment to universal human values: The time is ripe for those committed to the health and well-being of the poor and marginalised to join hands in a global coalition to respond to the current malignant forces of exclusion propagated by and for the benefit of the powerful. We must ensure that the great majority of people in our world are able to live with security and in human dignity."

Further information about Afri-CAN is available from: Afri-CAN Secretariat, P. O. Box 73860, Nairobi - Kenya.
Tel: 725003/729095. Fax: 711918.

Afri-CAN
Secretariat has expressed its deepest gratitude and sincere appreciation to all well wishers and partners for their support towards the realization of
Initiatives

Cardinal features that need close attention

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for a helping hand is critical.helping hand is more durable if it comes in the form of a health system that ensures sustainability of efforts and authentic involvement of communities.To support the establishment of CBHC, the Health System needs to take note of certain realities.It is critical that the health system endeavours to be supportive rather than suffocating.At this point in history there is a definite challenge for health systems to be supportive to community efforts.Even the world recognises these community efforts!The following are some of what I have found to be cardinal features that need attention in developing a system that is supportive rather than suffocating to CBHC.The health system is to help establish processes at the community level that empower people by helpingthem to acquire information and skills that would help work on solutions to their problems.The system needs to provide resources in a flexible context to get the process going.The system can also help CBHC in the context of helping to open up to the people, a widened horizon of possible options available to them from which to choose the strategies to apply as they search for solutions that are affordable.It is the responsibility of government to establish an overall framework and guidelines for safeguarding this flexibility.Otherwise, people can be gangpressed by those whose interest is to get out reports rather than facilitating the process of empowering people.

Procedures for Referral

The death bed for many potential CBHC activities is failure to establish a functional referral process.In this kind of situation a Traditional Birth Attendant (TBA) notices that a woman in obstructed labour is going to die and the TBA can do nothing further but to watch her die.Or the Community Health Worker (CHW) notices that a child is severely dehydrated and can't take fluids by mouth and all the CHW can do is to watch the child die.Nothing can be more demoralising to the TBA and CHW.Nothing erodes the credibility of CBHC more than watching people die when the death could have been prevented.Nothing could be worse than this in the eyes of community members and other observers. These events cast a negative shadow over everything regardless of what successes CBHC may have brought about.Therefore, for the purposes of saving lives and for sustaining credibility in order for the health promotion and disease prevention activities to continue, effective life saving referral procedures are critical components of a CBHC.Reports are coming up which are undermining the importance and value of TBAs because they don't do much to stop mothers from dying.And a number of agencies are having second thoughts about the value of TBAs and whether they should support TBA programmes.Maligning the contribution of TBAs is unfortunate.The role of TBAs is not only preventing death.TBAs also provide moral and social support and contribute to a general state of wellbeing.When TBAs are appropriately equipped and linked to the referral system, they also contribute to significant reduction of maternal mortality.Just as Kenya Medical Research Institute (KEMRI) and other institutions have annual conferences at which they compare notes and learn something new, the health system and partner NGOs need to provide for annual reviews of CBHC at various levels.On the first level, review workshops or conferences should involve headquarters, provincial and district levels together with those involved in actual community level activities.On a second level, this annual review should involve the District Health Management Team, NGOs working in the district and representatives from all communities where CBHC is taking place in the district.These reviews should include planning for expansion.It is stimulating to all those involved in any activity including CBHC to see that what they are doing is being taken seriously and being provided opportunity to share experiences.In my judgment, development of a responsive health system in support of CBHC should be given equal priority (if not higher) with other national programmes of importance.Countries may need to consider such events as declaring a CBHC week because changes at the community level will send ripples in the entire system and greatly facilitate health and overall development.

The above are excerpts from a paper Dr Were presented at the First International Conference on Community Based Health Care in Nairobi in March last year.The writer is a Kenyan working for the United Nations Population Fund (UNFPA)as Director of the Country Support Team (UNFPA/CST) for East and Central Africa and Anglophone West Africa based in Addis Ababa, Ethiopia.

Site inspection— concerns about community health

Impact of rural health motivators in Swazi

Swaziland's per capita expenditure for health is one of the highest in Sub–Saharan Africa, but this high spending is not transformed proportionately and significantly to better health. The poor health status can be attributed to a number of factors existing in the present health care system [MOH/WHO; 1995]:

I. inadequate and inaccessible services to the consumers. This is partly due to the scattered nature of the population and because of the increasing inability of the health services to cope with the demands of rapidly growing population. Inadequacy of the infrastructure could be said to be greatly reducing accessibility to the services;
II. misallocation of resources and poor sectoral linkages. Although 85 percent of the population is rural, the concentration of resources, both human and material, is urban oriented;
III. Poor health services delivery. Centralisation of decision making, including selection and recruitment of staff is a major contributor to poor patient management and quality of care at all levels. There is low level of technical and managerial capacity at regional level coupled with poor supervision and control as well as logistical management and accountability at the periphery.

Swaziland adopted Health Policy based on Primary Health Care (PHC) in 1983. As part of this PHC strategy, the Ministry of Health introduced a policy of decentralization. Each of the four regions has a Regional Health Management Team (RHMT) which oversees the functioning of the health services in the area. A lot of efforts have since gone into implementing PHC and to improve coverage and access of the communities to health care. The MOH has developed partnership and linkages with the private sector and Non–governmental organisations (NGOs) in the provision of health services.

The process

Over the years, the roles and responsibilities of the Rural Health Motivators (RHMs) have increased due to additional demands as dictated by community situations such as drought relief, epidemics, the changing disease profile, shortage in clinic staff and community development activities. The major concern therefore, is whether RHMs are still able to carry out their responsibilities effectively.

In 1976, the Government of Swaziland established a social mobilisation programme of Community Health Workers called the Rural Health Motivators (RHMs) Programme. The programme was seen as a vehicle for facilitating the extension of health education activities to the community level.

Two major consequences of this move included the decentralisation of the Swaziland Health Services and the establishment of Regional Health Management Teams in each of the four geographical regions. One may hypothesize that the adoption of PHC as a strategy would have given impetus to focus on extension of health services to the communities, which was central to the RHM programme.

Programme Evaluation

The Rural health Motivators programme was recently evaluated to find out the effectiveness of the programme in contributing to the efforts of the Swazi Government towards Health for All. Following is a summary of the findings of the evaluation.

What was achieved (outcome)

Based on findings of an evaluation, a number of achievements of RHMs stand out which serve to emphasise the role of RHMs as development motivators rather than purely health motivators:

- Improvement in environmental health and sanitary conditions, more particularly the construction and use of latrines.
- Significant number of homesteads are aware of the need to immunize their children.
- Significant number of homesteads have the capacity to manage diarrhoea at home
- RHMs are able to provide emergency deliveries to the homesteads.
- Significant number of homesteads are benefitting from first aid services provided by RHMs.
- RHMs have been able to link their communities with external resources, e.g., the destitutes and the aged with the department of Social Welfare and the victims of fire and other disasters with the Red Cross.
- RHMs have played a key role in the Community Based Rehabilitation programme where they have assisted

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Rural health motivators in Swaziland

A brief overview of the essential drugs concept, its components and development over the past 20 years, its successes and the constraints still faced is presented. This provides a broad picture of what is involved in getting the right drugs at the right time to the right client.

Rational management of essential drugs

In order to prevent creating too rosy a picture on essential drugs concept, it is important to look at statistics which show what has not yet been achieved, and why it will also be important for experts in health care in its various forms to find new, innovative ways of dealing with the persisting and in some areas worsening problems. Statistics will also identify those mechanisms which have proven to work and therefore merit strengthening.

Last year alone, an estimated 50 million people died world wide. Of these deaths, 40 million occured in developing countries, one third being children under five. Ten million were due to acute respiratory infections, diarrhoea diseases, tuberculosis and malaria; all conditions for which safe, inexpensive, essential drugs can be life-saving. Essential drugs are one of the most cost-effective elements in modern health care. But their potential can only be realised if drugs are accessible, correctly used, and of genuine quality. In absolute numbers, access to essential drugs has increased greatly over the last 20 years since WHO adopted the essential drugs concept and produced the first essential drugs list. Yet the WHO estimates that over one-third of the world's population still lacks regular access to essential drugs. In many of the poorest countries, especially in Africa and Asia, over 50% of the population may lack access to even the most essential drugs.

Prominence to essential drugs is given because firstly, given the curative, cultural and magical role of drugs, their presence in health services is indispensable to the proper functioning of the health care sector. Credibility, effectiveness, and attendance at health services, depend to a large extent on patients being able to obtain the relevant drug at the right time. A good diagnosis is not of much use if the patient cannot obtain the necessary treatment.

Secondly, while this century has witnessed an explosion of pharmaceutical discovery which has dramatically widened the therapeutic potential of medical practice, this potential has not been made available to all people and has thus not resulted in a proportionate improvement in health. Access to essential drugs remains limited and inequitable in many countries.

Over the past decades, governments in developing countries have faced great difficulty in procuring drugs at reasonable prices. Even if modern products could be afforded, the regulatory, control, equitable distribution, and rational use by prescribers and public alike have posed large problems. Not all drugs that were purchased represented value for money and met health priorities. Nor was it at all sure that they reach the places where they were most urgently needed.

In 1975 WHO defined essential drugs as those drugs which meet the health needs of the majority of the population, and published the first model list of essential drugs, containing about 200 products, in 1977. In 1978 the essential drugs concept was built into the declaration of Alma-Ata, which identifies access to drugs as a basic element of primary health care. The provision of essential drugs is therefore a core component of the strategy - for bringing about health for all.

The Model List sparked off a revolution in international public health. It initially resulted in a very mixed response including the prescriber's fear of lack of choice and the industry's fear of lack of income. It became increasingly clear however that if real health needs are to be met and if there is to be equal access to appropriate health care, countries cannot afford to waste scarce resources on drugs which either do not meet these majority needs or which are priced at a level which society cannot afford. Nor is the 'freedom to prescribe' a true freedom when it is not possible for the prescriber to individually evaluate the thousands of drug products being promoted or if it jeopardises access to health care needs of the majority.

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Guidelines for drug donations

Selection of drugs

1. All drug donations should be based on an expressed need and be relevant to the disease pattern in the country. Drugs should not be sent without prior consent by the recipient.

   Justification and explanation
   This provision stresses the point that it is the prime responsibility of the recipients to specify their needs.
   It is intended to prevent unsolicited donations, and donations which arrived unannounced and unwanted.
   It also empowers the recipients to refuse unwanted gifts.
   Possible exceptions
   In acute emergencies the need for prior consent by the recipient may be waived, provided the drugs are amongst those from the WHO Model List of Essential Drugs that are included in the UN list of emergency relief items recommended for use in acute emergencies.

2. All donated drugs or their generic equivalent should be approved for use in the recipient country and appear on the national list of essential drugs, or, if a national list is not available, on the WHO Model list of Essential Drugs, unless specifically requested otherwise by the recipient.

   Justification and explanation
   This provision is intended to ensure that drug donations comply with national drug policies and essential drugs programmes. It aims at maximising

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Drugs: policy and legislation framework

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The essential drugs concept was developed based on the following observations and guiding principles that:

- in any healthcare setting, the majority of health problems can best be treated with a limited range of carefully selected drugs;
- most clinicians routinely use less than 200 drugs; training should emphasise the proper use of these few drugs;
- supply and quality assurance activities can be carried out most efficiently and most economically for such a selected range of pharmaceutical products;
- patients can be better informed about the proper use of drugs when dealing with fewer drugs.

The essential drugs concept is consistent with the best of modern, evidence based medical practice. The concept is as valid to day as it was twenty years ago and it has helped to bring about change in the therapeutic thinking in all parts of the world including in some of the most advanced settings in developed countries.

It is very important to note that the essential drugs concept does not exclude the use of drugs which are not included in the essential drugs list. Second and third line drugs for common health problems and drugs for uncommon problems are also needed. But the essential drugs concept does focus selection, professional training, public information, and financial resources on those drugs which represent the best combination of efficacy, safety, quality, and cost for any given health care setting.

National Drug Policy (NDP)

Developing a national essential drugs list, which is in most cases an adaptation of the WHO model list, is only one of the desirable building blocks, although perhaps the keystone, of the essential drugs concept and a well functioning pharmaceutical sector. The reason why many countries lack adequate supplies of drugs which are appropriate for their health needs are complex and include financial and budgetary constraints, lack of infrastructure and human resources, and the attitudes and behaviour of the government, prescribers, dispensers, consumers and the pharmaceutical industry.

A national drug policy is both a stated commitment to a goal and a guide to action. The policy identifies the long-term goals and strategies for development of the pharmaceutical services. Individual components of a national drug policy typically address the legislative and regulatory framework, selection, supply strategies, quality assurance, rational use, economic strategies, human resources development, monitoring and evaluation, research, and technical co-operation amongst countries. A well developed national drug policy is one which is seen as a process rather than a product as such. It begins with problem identification and continues to policy formulation, official adoption, implementation and monitoring. Its success is affected by political, technical and economical factors and it is best developed with the active involvement of all the key stakeholders, including the health, commerce and other concerned government ministries; professional associations; non-governmental organisations; the private sector and the consumers. This way, the NDP is internalised and carried by a wide as possible a representation of the government and society at large.

Legislation and regulatory framework

The NDP being the statement of intent must be backed by appropriate legislation and regulatory control. Laws must clarify what is permissible and what is not in the field of pharmaceuticals, who may manufacture or import drugs, and who may prescribe them. Legislation must ensure that available drugs are of acceptable quality, safety and efficacy, and that their storage, availability and distribution is regulated Legislation is also needed to lay down the regulations and professional codes related to the prescribing and dispensing of drugs.

Technical guidelines have been produced by WHO and other international bodies for virtually all aspects of drug regulatory control, including drug registration, licensing and inspection, quality assurance, and control of drug information. Nevertheless, drug quality is a growing concern, and substandard and counterfeit drugs are a growing threat to health. The challenge now for countries is to find practical approaches to better implement existing regulations and guidelines.

Selection of essential drugs

It still holds today that the single most effective step in organising the drug market is selection of drugs that are allowed to circulate in the country. There are about 100,000 brand-name drugs in the world for less than 1000 active substances. Selection of drugs should always be done in the light of the health needs of the publication. Selection implies a balancing of different variables: efficacy, safety, cost, health care infrastructure and the ability of the health workers at different levels to diagnose and treat the diseases prevalent locally.

For the private sector, this selection takes shape in the form of drug registration and it may, depending on the registration criteria, result in anything between say 1000 and 10,000 items on the market.

For the public sector, a national essential drugs list will typically include from 10 to 15 drugs at the village level, 30 to 40 drugs at the health centre, which are by the way the 30 or 40 drugs which will suffice for 80 to 90% of all complaints, 100 to 120 drugs at district and provincial hospitals to the full range of 200 to 400 drugs at a teaching hospital.

This prioritisation is the cornerstone of any national drug policy as it has such profound impacts on all the other components.

It is important to stress that essential drugs are, using therapeutic, economic and managerial considerations, the best possible medicines in their specific health, social and economic setting. Essential drugs are not second-rate drugs, they are not for rural areas only and they are not for poor countries. The concept for essential drugs is universal as it leads under any condition to better health care at a price the community can afford.

Drug financing

Changing models of socio-economic development, globalisation in trade,

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Donated drugs: Factors to bear in mind

from page 15

the positive impact of the donation, and prevents the donation of drugs which are unnecessary and/or unknown in the recipient country.

Possible exceptions
An exception can be made for drugs needed in sudden outbreaks of uncommon or newly emerging diseases, since such drugs may not be approved for use in the recipient country.

3. The presentation, strength and formulation of donated drugs should, as much as possible, be similar to those commonly used in the recipient country.

Justification and explanation
Most staff working at different health care levels in the recipient country have been trained to use a certain formulation and dosage schedule and cannot constantly change their treatment practices. Moreover, they often have insufficient training in performing the necessary dosage calculations required for such changes.

Quality assurance and shelf-life
4. All donated drugs should be obtained from a reliable source and comply with quality standards in both donor and recipient country. The WHO Certificate Scheme on the Quality of Pharmaceutical Products Moving in International Commerce should be used.

Justification and explanation
This provision prevents double standards: drugs of unacceptable quality in the donor country should not be donated to other countries. Donated drugs should be authorised for sale in the country of origin, and manufactured in accordance with international standards of Good Manufacturing Practice (GMP).

Possible exceptions
In acute emergencies the use of the WHO Certification Scheme may not be practical. However, if it is not used, a justification should be given by the donor. When donors provide funds to purchase drugs from local producers, those which comply with national standards should not be excluded on the sole grounds that they do not meet quality standards of the donor country.

5. No drugs should be donated that have been issued to patients and then returned to a pharmacy or elsewhere, or were given to health professionals as free samples.

Justification and explanation
Patients return unused drugs to a pharmacy to ensure their safe disposal; the same applies to drug samples that have been received by health workers. In most countries it is not allowed to issue such drugs to other patients, because their quality cannot be guaranteed. For this reason returned drugs should not be donated either. In addition to quality issues, returned drugs are very difficult to manage at the receiving end because of broken packages and small quantities involved.

6. After arrival in the recipient country all donated drugs should have a remaining shelf-life of at least one year.

Justification and explanation
In many recipient countries, and especially under emergency situations, there are logistical problems. Very often the regular drug distribution system has limited possibilities for immediate distribution. Regular distribution through different storage levels (e.g. central store, provincial store, district hospital) may take six months. This provision especially prevents the donation of drugs just before their expiry as in most cases such drugs would only reach the patient after expiry.

Possible exceptions
An exception should be made for drugs with a total shelf-life of less than two years, in which case at least one-third of the shelf-life should remain. An exception can also be made for direct donations to specific health facilities, provided the responsible professional at the receiving end is aware of the shelf-life and the remaining shelf-life allows for proper administration prior to expiration. In all cases it is important that the date of arrival be communicated to the recipient well in advance.

Presentation, packing and labelling
7. All drugs should be labelled in a language that is easily understood by health professionals in the recipient country; the label on each individual container should at least contain the International Nonproprietary Name (INN, or generic name), batch number, dosage form, strength, name of manufacturer, quality in the container, storage conditions and expiry date.

Justification and explanation
All donated drugs, including those under brand name, should be labelled also with their INN or the official generic name. Most training programmes are based on the use of generic names. Receiving drugs under different and often unknown brand names and without the INN is confusing for health workers and can even be dangerous for patients. In case of injections, the route of administration should be indicated.

8. As much as possible, donated drugs should be presented in larger quantity units and hospital packs.

Justification and explanation
Large quantity packs are cheaper, less bulk to transport and conform better with public sector supply systems in most developing countries. This provision also prevents the donation of drugs in sample packages, which are impractical to manage. In precarious situations, the donations of paediatric syrup and mixtures may be inappropriate because of logistical problems and their potential misuse.

9. All drug donations should be packed in accordance with international shipping regulations, andbe accompanied by a

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Drugs selection, financing, supply and use

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harmonisation of pharmaceutical markets, shifting public and private roles, increasing external debt, and macro-economic changes each create challenges for governments and other organisations in terms of health care, and drug financing.

In most high-income countries, national health schemes and private health insurance cover 90 to 100 percent of the population and 50 to 70% of the drug costs. In most developing countries, by contrast, less than 10% of the population has health insurance and 60 to 90% of drug costs are paid for directly by patients and their families.

Health sector reform should strive to improve equity, quality of services, efficiency, and public satisfaction with health services. Continued solidarity in provision of social services is a major concern in such a change process. The essential drugs concept, of which the optimal use of limited resources has always been a core consideration, may greatly help to minimise adverse implications of reform.

Supply

As essential drug lists use generic rather than brand names, procurement of drugs, especially bulk procurement by generic names, has resulted in dramatic cost-savings. This is because generic drugs with the same active ingredient are often 50% or less than the price of the leading brand.

The actual distribution of drugs, the logistical process of procuring, storing and distributing drugs to the end user is still very much under development in many countries. In the public sector, drug supply system is increasingly being replaced by alternative distribution systems which vary from parastatals that are operationally independent from the MOH and which are able to charge for their services on a cash-and-carry basis, to other, more commercially oriented, systems.

Rational use

Even after the drugs have finally reached their destination, the health care facility, the way they will be used is still a cause for worry.

Between one-quarter and three-quarters of antibiotics are prescribed inappropriately, even in teaching hospitals. Studies of pharmacies in developing countries have found that 90% of customers purchase three days supply or less of antibiotics; half buy only one day's supply. On average, 50% of patients world-wide fail to take their medicines correctly, resulting in excess mortality from common infections, emergence of resistance to drugs, and inadequate treatment of chronic illnesses such as hypertension.

Several interventions are being used to ensure sensible prescribing, dispensing and use of drugs. Basic training of medical doctors and other health care professionals is currently based on principles of good prescribing and use of generic drugs. Prescribing and dispensing is increasingly subject to standardised protocols and monitoring and supervision. And in a number of countries, creative approaches to public education and rational drug use have been developed.

Essential drugs as a tool for quality care for all

The importance of essential drugs *as items* for quality care are clear. There are also lessons which can be learned from essential drugs as a *concept and approach* which may serve as a basis for further development of equitable, accessible, and quality health services in its entirety.

The ED Concept is one of the successful components of Alma Alta declaration because:

- It aims at the concurrent development of a political and legal framework and practical, tangible, technical, activities.
- It addresses real problems in a long term concerted effort using clear and simple principles.
- It prioritises the use of limited resources.
- It is truly universal concept, it makes professional sense regardless of the specific local social and economic environment.

Another lesson which can be learnt from the essential drugs concept is that not all parts of health care provision are best decentralised or privatised. There will always be certain functions which are better dealt with at the central level in view of the necessary control or the advantages of economy of scale ,e.g., the selection of drugs that are authorised for circulation and the setting of quality standards.

ED AND CBHC

Looking at CBHC from a pharmaceutical angle, things are not all that clear as to what are its competitive advantage over alternative health care delivery systems.

What is the role and responsibility of the Community Health Worker, and what is the service which this semi-formal, or semi-voluntary member of the health fraternity provides which is not, should not, or can not be provided by alternative delivery mechanisms, for instance through the private sector? How should their role *vis-à-vis* the Dispensary or Health Post level or even the drug seller be defined? In many countries their professional status is still not clarified in an appropriate legal structure, nor is their education, their registration, and their supervision. They often handle prescription-only drugs such as antibiotics. Should this situation be tightened, or should we rather allow them to expand their services as this is the best way of reaching the community? If we opt for the latter, what level of training will be required, what level of care can and should be provided by them and how do they link with the regular health services?

And what about equity? How do we ensure that health care delivery systems which are increasingly forced to charge fees for even the most basic of services will continue to be accessible to all citizens? Does the answer to this problem lie with western style financing mechanisms or is it better left to the community and CBHC to devise suitable local coping mechanisms?

This article is developed from a paper presented by Peter Graaff of the Kenya National Drug Policy, Pharmacy Department of the Ministry of Health in Kenya, during the 1st ***International Community Based Health Care Conference*** *held in Nairobi in March 1997.*

Achievements of rural health motivators

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with the identification of cases, but more particularly with the education of the community, and hence the lowering of stigma attached to disabled.

- RHMs play a key role in the drought relief programme.
- RHMs have become a reference point for community development – e.g. vegetable gardens, handicraft, and sewing.
- RHMs have played a key role in nutrition, education, more particularly with the formation of mother support groups.

Strengths of the programme

- RHMs more than anybody else knows the needs of their communities.
- RHMs serves as a point of entry to the community. They are more open and knowledgeable than the rest. Unfortunately, because of this advantage, everybody looks up to them for mobilisation and monitoring.
- RHMs form the basic part of IEC strategy for the various sectors and programmes.
- RHMs perform the advocacy and linkage role for their communities – they know where to go for external resources (roads, clinics initiated through RHMs).

Challenges: Use of RHMs

The involvement of RHMs in the proposed Home–Based Care and Prevention Programme (HBCP) represents an added responsibility; granted that RHMs are already carrying out some elements of home–based by , for example, visiting the sick or mothers who have delivered. Yet, a RHM, given the strengths described here, is probably the best placed person to guide the process at community level.

The challenge, therefore is how to involve RHMs in HBCP without overburdening them and hence running the risk of spreading their other services thinly on the ground. The HBCP will need effective community structures to support it.

The expanded Inkhundla Development Committee, with its additional members and new roles represent such a structure. It embodies team approach, which is central to the success of the proposed Home–Based Care and Prevention Programme.

Weaknesses of the programme

The main weaknesses in the programme is lack of supportive supervision. In this study, supervision emerges as a factor that seems to underpin all the activities of the Rural Health Motivator. It is related to the morale of the RHM and a feeling of both accountability and belonging to the programme. It is supervision that should provide that necessary but lacking system of reinforcement of the work of RHMs. It is through regular monitoring of the activities of the RHMs that the programme could be said to be in a position to determine the capacity of the RHMs to respond to the changing needs of their communities, and hence determine the type of continuing education the RHMs need to respond to these demands.

At issue is not how to increase the absolute number of visits by the RHM Trainer, but how best the Trainer can utilize the time she spends at the community, and what role community based structures, including the health facilities can play in the system of supportive supervision.

Other major weaknesses of the programme include the following:

- Not having full time RHM Trainers – relieved from other duties.
- Lack of a feeling of ownership of the programme by the community.
- No clear contact with health facilities.
- Clinics see RHMs as an "extra pair of hands" and not as a member of the health team.
- The process of introducing the programme to communities is weak.
- The fact that most RHMs are females. Increasing number of males would give it status and make the programme lend itself more easily to programmes where the sex of the provider is an important factor, for example HIV/AIDS.

Lessons learnt

Information

The programme has no systematic method of collecting, compiling, analyzing, interpreting, using and storing information. Although RHMs collect information, there is no indication that this information is compiled and analyzed for use in planning programme activities or for giving advice to RHMs.

Supervision

The major weakness is that there is no means of verification of the data collected since there are no field supervisions of RHMs.

Community Own Resource Persons

The present status leaves RHMs subject to abuse and misuse to the point that RHMs are having to operate a whole week of community work rather than the designated two and a half days a week. There is need for diversification of community Community Own Resource Persons in order to avoid overburdening the few. It is important to have a system for rewarding accumulated knowledge, skills and experience.

Need for Policy framework and implementation guidelines

The programme has no mechanism for coordinating the involvement of the NGOs and the various Government departments with the RHMs.

The future of the programme

As a follow up to the evaluation the programme will need to be assisted to come up with a Five–Year Strategic Plan based on government policy which will target all levels of the programme management:

Government Role in Policy Formulation

- Ministry of Health jointly with the Deputy Prime Minister's Office needs to draw policy guidelines to facilitate effective linkages between health facilities, community structures and the programme.
- Ministry of Health should draw up

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Challenges of health motivators in community in health programmes

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policy outlining essential obstetric functions of clinics. To this extent consideration should also be made for providing all the RHMs with TBA training.

Design and Management of the Programme

Government level

Ministry of Health needs to develop policy on RHM programme management and coordination at central, regional, health facility and community level.

Ministry of Health should develop a policy to guide the coordination of all community based health programmes.

Community level

Training and Capacity Building could produce a cascade effect using the following strategies:

- RHM Trainers should be made full time employees of the programme.
- RHM Trainers should be provided with an opportunity to be retrained or attend Trainers of Facilitators Course to strengthen their skills in programme planning, programme monitoring and evaluation, supervision and training.

A system of rewarding accumulated knowledge and skills of RHMs should be devised. Consideration should be made for making them Trainers of Trainers of Facilitators. The latter will go a long way towards decentralising training. More senior and more experienced RHMs should be involved in supervising other RHMs.

A period of internship should be built into the present system of training RHMs.

Sustainability of the Programme

As part of sustainability, RHM should be strengthened to become focal points for development and change – a role they have already assumed.

Conclusion

If scaling up has to happen there is need for government framework and clear guidelines on plans that can enable smooth implementation of the programme. The network of RHMs straddled across the Kingdom of Swaziland presents an immense opportunity for Government to implement PHC policy and other community based initiatives. In the past twenty years RHMs seem to have survived the constraints related to the management of the programme. RHMs have emerged as broad based community motivators whose roles seem to be increasing from day to day. Therefore, for Swaziland Government to obtain the maximum benefits from this group of committed citizens, working under difficult circumstances, there is need to develop clear policy guidelines and necessary infrastructure to support them. Motivated RHMs hold the key to health and development in the Kingdom.

*The report was extracted from an evaluation entitled "**The role of Rural Health Motivators in Community Health and Development in the Kingdom of Swaziland**" by Lucas Owuor–Omondi, Elizabeth Mndzebele and William Okedi.*

Unannounced drug donations

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detailed packing list which specifies the contents of each numbered carton by INN, dosage form, quantity, batch number, expiry date, volume, weight and any special storage conditions. The weight per carton should not exceed 50 kilograms. Drugs should not be mixed with other supplies in the same carton.

Justification and explanation

This provision is intended to facilitate the administration, storage and distribution of donations in emergency situations, as the identification and management of unmarked boxes with mixed drugs is very time and labour intensive. This provision specifically discourages donations of small quantities of mixed drugs. The maximum weight of 50Kg ensures that each carton can be handled without special equipment.

Information and management

10. Recipients should be informed of all drug donations that are being considered, prepared or actually underway.

Justification and explanation

Many drug donations arrived unannounced. Detailed advance information on all drug donations is essential to enable the recipient to plan for the recipient of the donation and to coordinate the donation with either sources of supply. The information should at least include: the type and quantities of donated drugs including their International Nonproprietary Name (INN or generic name), strength, dosage form. manufacturer and expiry date; reference to earlier correspondence (for example, the letter of consent by the recipient); the expected date of arrival and port of entry; and the identity and contact address of the donor.

11. In the recipient country the declared value of a drug donation should be based upon the wholesale price of its generic equivalent in the recipient country, or, if such information is not available, on the wholesale world-market price for its generic equivalent.

Justification and explanation

This provision is needed in the recipient country to prevent drug donations being priced according to the retail price of the product in the donor country, which may lead to elevated overhead cost for import tax, port clearance, and handling in the recipient country. It may also result in a corresponding decrease in the public sector drug budget in the recipient country.

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Africans may be tired of hearing about AIDS, yet must face the reality of its scourge constantly: funeral after funeral. This article focuses on the question of whether or not HIV-positive mothers should take the risk of breast-feeding their babies.

Breast or bottle for babies of AIDS mothers

By Bob Kanika

Six months after she gave birth to a bouncing baby girl. Nereah Anyango began to notice a steady deterioration in the infant's health. At first it was diarrhoea. When the baby seemed to have recovered from this wasting ailment, pneumonia set in. Then it was a dry, stubborn cough. Despite many visits to various health centres to try to have her first and only child with her childhood friend-turned-husband, Charles recover her health, no visible signs of recuperation were seen.

Two months later the child died. And before the young couple could recover from the effects of the loss of their daughter, the mother too began to be sickly. Before very long, Charles health also started deteriorating.

On the advice of the clinical officer at the local health centre, the couple went to the Migori district hospital in western Kenya for blood screening. To their utter horror and dismay, they both tested positive for HIV. It was not long before the couple died, one after the other, what with ravaging effects of the AIDS-causing HIV virus and the worries that befell them.

Nereah is just but one of the many mothers who have transferred the HIV virus to their babies through breast-feeding, rekindling the global debate on whether or not mothers should breast-feed or rely on artificial milk formulas and cow milk. The debate is raging, in particular, in Kenya where AIDS is killing an average of 111 people a day, according to the health ministry.

In 1996, a Kenyan cabinet minister told Parliament that the dreaded disease had killed about 60,000 Kenyans during the period between January and June of 1995.

According to a regional AIDS control and prevention project, about 2 million Kenyans may now be infected with the HIV virus. And, taking into consideration the fact that women outnumber men by 53 to 47 in Kenya, the number of mothers of child-bearing age who are HIV-infected could be vast.

Global research has shown that HIV-infected mothers may in turn infect their children through breast-feeding.

A recent issue of the United Nations Children's Fund (UNICEF) annual report, "State of the World's Children," says that children born of HIV-infected mothers run a greater risk of contracting AIDS when they are breast-fed than when they are fed on artificial formulas.

The flip side of the debate is the despicable sanitary conditions, especially in the poor countries. In such a situation, children are more likely to die from such infections as diarrhoea when they are bottle-fed than when breast-fed.

According to Mike Mailey of the Institute of Child Health in London, babies who are not breast-fed run a higher risk of pneumonia and diarrhoea due to poor hygiene and dirty drinking water in which the bottle milk is prepared. This argument is torpedoed by the fact that infants fed on artificial formulas have a lower intelligence quotient (IQ) than their breast-fed counterparts.

Bailey says that research has established that bottle-fed children are more predisposed to such infections as asthma and, in their adult lives, are more prone to hypertension and heart diseases. Thus, in order to decide whether breast-feeding or bottle-feeding is preferred, one must weigh the risk of infection through breast-feeding against the grave dangers posed by artificial feeding.

Medical experts the world over have reached the consensus that infant mortality from respiratory infections and diarrhoea as a result of lack of safe and reliable feeding alternatives may outweigh that from HIV-positive mothers. This is most probably why the Breast-feeding Information Group (BIG) recommends that HIV-positive mothers with access to clean drinking water bottle-feed their children to save the infants from possible contraction of the AIDS-causing virus. But will this not result in discriminating one group of women against the other ... the poor against the better endowed?

Bailey offers one viable solution to this seeming impasse. He recommends sensitizing the women on the spread of HIV and AIDS. "The HIV-positive mothers should be given as much information as possible on the risks involved in each method so that they may make an informed decision," he says.

But at the moment, even the women are confused as to what option to take. In Kenya, the government is non-committal as the women, although it says lamely that infected women be advised not to breast-feed. The health ministry's sessional paper No. 4 of 1997 on AIDS says: "Pregnant women with HIV infection would be advised to avoid breast-feeding as an intervention strategy." But in the government health institutions, especially the health care and maternity clinics, mothers, including those with HIV infection, are encouraged to breast-feed.

The Ministry of Health seems to be trapped in a 'Catch 22' situation. Says a senior ministry official: "Of course we are aware of the inherent dangers. But we are still adhering to the World Health Organisation (WHO) guidelines. The government adopted the WHO guideline as a policy, and the guideline is that breast-feeding be encouraged."

The official adds that the ministry is still waiting for Parliament to pass a law on this matter.

The situation is particularly sensitive because most Kenyans still opt not to go for HIV testing for fear of being stigmatised and ostracised. Moreover, even those who are known to be affected do not wish to be told so. This makes the scenario even more hopeless.

Should HIV-positive mothers be told they are affected, or should they not? This is the question the Kenyan medical authorities are grappling with.

Yet another snag is the cost of the alternative feeds. Most Kenyan women cannot afford the artificial formulas or cow milk

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South Africa

White Paper for health system

By Bea Abrahams

In April 1997, Dr Nkosasana Zuma, South African Minister for Health, released the Department of Health's White Paper. It spells out the department's vision for a new health system, where all people can have access to affordable health care services, regardless of their race, colour, religion or gender.

The White Paper consists of 21 separate chapters, each dealing with different aspects of the new national health system. The aim is to have a unified health service; to ensure that all people have access to the same services, based on the Primary Health Care (PHC) approach; to give priority to the health needs of women, including pregnant women, and children; and to involve communities and the private sector in health matters.

The White Paper also goes on to raise specific issues. These include:

How will the Health Sector be recognised?

The Department of Health has adopted the District Health System (DHS) to provide services at the national, provincial and local levels. Based on the PHC approach, the DHS is seen to be the most effective and least expensive way of improving the nation's health status. The White Paper lists a number of important services which are going to be in the PHC package to be provided through the DHS.

How will the Health Sector be financed?

For many years, money and equipment in South Africa was channeled into big hospitals in the big cities or towns. The needs of the small community clinics were neglected, or in some areas no clinics existed. For new health system to be successful, PHC clinics will have to have proper equipment and drugs, so that people can effectively make use of them. First, hospital equipment, important and essential medicines and other resources must be channeled away from the big hospitals into the PHC clinics. Second, in addition to the funds given by government, provinces will also have to look at other ways of finding money for health services. This could be done by charging an affordable fee for hospital services and then keeping that money within the province.

Developing the skills of Health Workers

Health workers will have to be trained in the PHC approach so that they can deliver good quality services. To ensure the same kind of training in different provinces, national guidelines will be drawn up. There will also be Primary Health Care Teams at clinics and community health centres. These teams will consist of a mixture of people from different professional backgrounds. For example, doctors, nurses, social workers and psychologists might all serve on the same team. These health workers will be able to deal with common problems and will also be able to make proper referrals to other health facilities.

How will the community become involved in health?

Different kinds of health committees will be set up so that communities themselves can participate in the planning and provision of health services. Communities will also be encouraged to help in setting health priorities, and to monitor how progress is made in the different areas. Women, in particular, will be encouraged, through skills training, to work closely with government and non-governmental health workers. The Department of Health also promises to keep the public informed about health matters, progress and difficulties, and to work out different ways of ensuring that "ordinary people" play a role in developing health policies.

Other matters addressed in the White Paper include chapters on HIV/AIDS, sexually transmitted diseases, mental health, communicable diseases, environmental health and the role of NGOs. Each chapter sets out a strategy for dealing with these specific health problems, the time frames within which progress should be made and the results that are expected.

The writer is the Manager, NPPHCN Public Health Interventions through Legislative Analysis (PHILA) Programme.

D. R. Congo

Health rehabilitation

Launching of the second phase of the Programme of transitory support to the health sector (PTSHS).

Brief historical survey

In 1994, following the suspension of direct cooperation with the then Zaire (today the Democratic Republic of Congo) and in order to provide humanitarian emergency help to the people of Congo, stricken by three decades of mismanagement of public treasure, the European Commission decided to set up a programme of Transitory Support to the Health Sector (PTSHS). PTSHS I started in 1994, with the arrival of technical assistance. Three Technical Support Offices (TSO), headed by expatriate physicians with specialization and experience in public health, started in three regions of intervention: Kinshasa, the two Kasai (with TSO in Mbuji–Mayi) and the North and South Kivu provinces (with the TSO in Goma).

Between January and June 1995, 50 projects initially planned for two years, but later on extended for three further months till October 1997, was signed with NGOs operating in health sector. The contribution of the European Union to the implementation of PTSHS I amounted to about 27 million ecus (35 million dollars). At the end of this first phase, PTSHS has achieved the following:

- Support to 32 health zones.
- Sustaining activities to fight against endemic diseases (tuberculosis, trypanosomiasis, leprosy, poliomyelitis, measles, ...), or projects to fight against the spreading of STD/HIV/AIDS and against the Ebola fever.
- The response to specific problems (food crises, malnutrition, drinking water, sanitation, assistance to displaced persons within the Democratic Republic of Congo).
- Sustaining activities of competent Congolese and the revitalization of the health sector.

Functioning and objectives of PTSHS

In the absence of direct, classical cooperation of the European Union, the PTSHS provides humanitarian help. The most privileged partners of the programme are

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the Congolese Civil Society (confessional and free lay NGOs, NGOs supported by other organisations) and European NGOs. For more efficiency on the field, the PTSHS has set up a closer technical assistance through the action of the Technical Support Offices (TSO), which are established in the target regions of intervention and directed by specialist physicians in public health. The TSO make it possible to control the projects efficiently and adapt them on the field. In some cases, the TSOs had to help in the elaboration of projects or in fixing the orientations. In other cases, they had to suggest a grouping of a partnership in order to ensure sustainability. In general, however, all these projects start from a local initiative.

The criteria for the selection and the intervention in the projects are the operationality of the project and the response to the needs of the Congolese population. The beneficiaries are the mass of have–nots whose purchasing power constitutes an obstacle to access to primary health care.

The PTSHS pursues realistic objectives: to limit the degradation of some health structures so as not to lose the human capital of the DRC. All the projects aim at enabling the health structures to sustain means survival. Each of them has a specific level of self reliance.

Forward with PTSHS II .

Tributary to the decisions of the European Commission and consecutively to Lome III and Lome IV, PTSHS II follows in the steps of PTSHS I, which ended its activities at the beginning of January this year. It employs 7 expatriate technical assistants and will have to collaborate with another 15 Congolese auxiliaries. The tasks of the coordinator are: the implementation of the programme and the relations State – NGOs. Mrs. Moreau, responsible for the administration and the finances of the programme, will deal with customs clearances and the financial control of the projects. Mr. Detienne, sanitation engineer, is responsible for the issues related to water and sanitation. Mr. Antonin, a logistician, is responsible for the establishment of offices and the control of the rehabilitation aspect of the projects. Dr. Lambert will supervise all the technical support offices and he will be assisted by Dr. Mirindi, a Congolese, for Kinshasa, Dr. Vanderveken for the two Kasai and Dr. Denis for Kivu.

The global objective of this second phase is to maintain and reinforce the level of access to and the quality of care reached at the end of PTSHS I.

PTSHS II consist of a set of projects of three years each, implemented by partners of the civil society, responding to the needs of the population and taking into account the criteria of feasibility (geographical accessibility, availability of competences, estimated impact). These projects are also concerned with preserving and revitalizing the elements of the health system, working first of all with the most functional. It consists both of providing support to the population and saving the vital institutional mechanisms: health zones, activities of coordination and supervision. All these projects are implied in the general framework for the implementation of the minimum action plan of the Ministry of Health.

The planned duration of PTSHS II is four years (from January 1998 to December 2001): six months for the selection of projects, three years for the implementation and six months for the closing. The total cost of the projects to be implemented is estimated to 45 million ecus (50 million dollars).

In an interview about the relations between the PTSHS and the government authorities, the PTSHS Coordinator, Dr. Simon indicated that they were excellent and added that the programme was expecting to help the Ministry of Health at the provincial level through the collaboration with provincial health inspectors, and at the national level, through epidemiological monitoring and the support, for three years, to the school of public health (training of the zone physicians). In this type of technical assistance which promotes partnership with the civil society, the PTSHS aims at encouraging the state in its specific role of coordination.

At the end of PTSHS II, the expected

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Zimbabwe

Support for NGOs

By Bongai Mundeta

Zimbabwe has experienced growth in a number of NGOs in the country since post-independence. Gender issues have been high on Zimbabwe Government agenda with special focus on women. As such several NGOs have emerged in support for several women's issues. Health issues for women have been the focus of many NGOs in Zimbabwe.

The women and AIDS Support Network (WASN) has been one of the NGOs concerned with NGOs and AIDS issues. Health education on sexually transmitted disease including HIV/AIDS has always been gender sensitive.

This programme has always been hindered due to cultural beliefs, poor communication skills and even fear of violence from men. WASN has worked extensively with women and a detailed research was done which revealed that many women in Zimbabwe would like to use female condoms to protect themselves.

Although the female condom has been introduced in other parts of the world, it was not accessible nor affordable for Zimbabwe women.

WASN organised a 'petition' to persuade the Ministry of Health to register the female condom as a drug and make it available to the population in an acceptable price.

Over 10,000 signatures were collected and presented to the Ministry of Health during AIDS week. Now the female condom is registered and available.

'So far 92,500 female condoms have been sold in Zimbabwe. The first six months supply was sold in 6 weeks'. (Felicity Snowsill 1997).

WASN has managed to be very effective in both gender sensitivity education as well as advocacy. Both exercises helped to meet the needs of the people.

The author is the Chief Training Officer of the Zimbabwe Red Cross Society

Nigeria

World Bank/IMF Structural Adjustment Programme caused havoc for a decade

By Dr. Rakiya Booth

Yohanna Samari is a 42 year-old teacher and farmer living in Bwoi, a rural area in the state of Bauchi,

Nigeria. He is married with five children - the eldest of which is 14 years and the youngest is 2 years. His eldest son is also working on the farm because Yohanna, despite being a school teacher, cannot afford to pay the secondary school fees.

In October 1997, the dispensary and maternal and child health clinic in Bwoi was forced to close down. Established by the Church of Christ in Nigeria (COCIN), the centre could no longer afford to maintain the revolving drug fund which supplied the drugs to the clinic and which covered the costs of the staff. Previously, the facility had served a community of 2000 - 2500 people and was the only health centre in the locality. I asked Yohanna what he thought about this closure.

"The clinic was a tremendous help to us here in Bwoi. I, myself, and my family benefited a lot from it. My wife received antenatal care at the clinic and my last two children were born there. Now, when any one of us falls ill, we have to look for a nearby clinic or go to one of the hospitals in Jos (70km). But this is not even feasible as I cannot afford the cost of hospital bills."

Curious, I asked him whether this was the only development that had adversely affected him. "No," he said. "For the past two years, there has been very poor yield from my farm. This is because the subsidy on fertilizer has been removed. Whereas we farmers could afford to buy bags of fertilizer, now we don't even see them, let alone buy them. As a result, the yield from the farm is very low and I cannot sell farm produce anymore to supplement my income."

To get an idea of family income, I asked him how much he received from his teaching job. "N2650.00 (US$ 31.20) per month," he said, "and sometimes it takes six months before we are paid."

Yohanna said many others were also facing increasingly difficult times. "For example, the staff at the clinic lost their jobs so some joined us to work on the farm. They needed to subsist and earn a living. Others have gone to different places to look for jobs. All the farmers are also affected because of the scarcity of fertilizer and because the price is beyond their reach."

The Bwoi clinic was one of 86 rural health clinics run by Church of Christ in Nigeria. Many health services in Nigeria are church-run. The Christian Health Association of Nigeria (CHAN) represents organisations which provide 40% of health care delivery within the country. Many church-related health facilities are suffering because the Nigerian government has withdrawn or reduced grants in recent years.

In the late 1980s, Nigeria succumbed to the demands of the World Bank and IMF and introduced a structural adjustment programme (SAP). There were massive retrenchments and many people lost their jobs. Certain subsidies were either reduced or withdrawn. Consequently, many people were thrown into hardship. Some government enterprises did not survive either. Although it is at least 10 years since the introduction of the structural adjustment programme, things have not yet returned to normal and many people are still suffering.

Dr Rakiya Booth, is Primary Health Care Coordinator, Christian Health Association of Nigeria

Impact of SAPs have kept these rural African chlildren out of school

Gender development —the Ugandan experience

By Grace Nakazibwe

What is gender?

Gender identifies the social differences between men and women, that are learnt over a long period or even generations. These differences are changeable over time and have wide variations within and between cultures. Gender is always learnt behaviour. The behaviours condition activities, tasks and responsibilities which are considered feminine and masculine.

Social Construction of Gender

This is the way society prepares boys and girls for their future roles as men and women. The boys play the role of men and the girls play the roles of women. Any deviation from this is not easily acceptable and in some cultures, it is completely unacceptable.

In some families, at a birth of a child, a boy may be welcomed with joy. In some societies, a goat is slaughtered to celebrate the birth of a boy child. In other cultures, a twin girl is killed in favour of a boy.

In schools or peer groups

You may find that teachers give more opportunities to boys in class than girls. Science subjects are expected to be done by males. All pictures of doctors are male.

When there is lack of school fees, the girl child is immediately discontinued. If there are problems at home, the girl child is asked to stay and help.

These examples show that the social differences are learnt from a very early age.

Gender Concerns

This is a concern that affect one gender negatively and it arises because of relationships between men and women that need change. There is always a disadvantaged sex in society as indicated in the examples above. This has brought about the Affirmative Action in order to address these concerns.

For example, in Uganda, there is a policy in place whereby one third of the local councils representatives are women, and that 1.5 points are given to girls joining university to increase their intake.

Gender Balances

This seeks to address imbalances to achieve gender equity and not equality as most people think, especially men. Equity means fairness that both men and women are judged fairly, that men and women get equal chances to do things to acquire and control resources, that men and women get equal opportunities in education, employment and that resources are distributed equitably.

Equality means, the same or alike. It can even mean parallel, which could result into rivalry and this would contradict the concept of partnership between men and women.

Gender and Development

Development is a positive change which may not directly be related to socio–economic development. It could be a positive change in a bad culture. Development can be gender positive. It can also be gender neutral. But if it is gender negative, can we call it development? Economic development versus social development favours men over women.

Gender and development recognises women and men as partners in development. There are three main corner stones in gender and development. These are equity, participation and sustainability, without which development and gender cannot be effected.

Gender and Development Strategy

This involves social and cultural change that integrate both men and women in the development process. It empowers both men and women to take part in developmental activities that influence their relationships. This empowerment also addresses the power over others, which is domineering and not sustainable. There is also power with which people are able to co–operate and mobilise others to do things, then power which is inside a person and which enables them to change the situation.

All these lyrics of power need to be considered in empowerment process. However, the most critical is the power within and this comes as a result of having rights and the ability to do something about it. Then there will be increased access for both men and women to resources and decision making.

The Uganda Government and Gender Development

Started by participating at the Nairobi Conference where the then First Lady led the delegation of Uganda. With the change of government the NRM started on the actual implementation of GAD using several fronts:

Political

- The Government started appointment of women Ministers.
- The Government established a department of women in the Ministry of Women in Development, Youth and Culture.
- Then later followed the establishment of Gender and Community Development.
- The new constitution ensured affirmative action on women's representation being one third at all levels of administration.

Decision making

- A woman Vice President
- At village level, at the local council which consists of ten people, four must be women although they can be more. These are elected by the village communities. Youth councils also constitute one third of women.
- There is a National Council of Women.
- There are gender offices at district level, National Council Women Representatives, Constituency Assembly Women Delegates, Members of Parliament, and gender sensitisation programmes.

Education

- 1.5 points for girls entering University.
- Universal Primary Education (UPE).
- Department of Women Studies at Makerere University.
- Health – emphasis on Reproductive Health.
- PHC prescribes to equity which includes the poor and the rich, women and men.
- Income – Geared to economic empowerment of women.
- Uganda Women Finance and Credit Trust Ltd.

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Can church congregation be a healing community?

By Rev. Michael Sande

The New Testament church was a healing community. At the beginning of His Ministry, Jesus revealed the Agenda for His mission when he said (in Luke 4:18) that his objective was

".... *to preach good news to the poor*
to proclaim freedom for the prisoners
to recover the sight of the blind
to release the oppressed"

This can be seen as a promise of restoration against a backdrop of depravity. Later on in His Ministry when John the Baptist sent his (John's) disciples to get a confirmation from Jesus that He is the Messiah, Jesus sent them to report what they hear and what they see, specifically that the blind receive their sight and the lame walk. "Those who had leprosy were cured, the deaf were able to hear, the dead were raised and the good news was preached to the poor" (Matthew 11: 4-5).

The church was to be one which proclaims, heralds, teaches and one which heals. So that when he says the purpose of his coming is so that "you may have life in its fullness" (John 10: 10) he does not compartmentalise the human being into little portions of physical, spiritual or social self. NO! Jesus offers spiritual healing, he heals physical infirmities, feeds the hungry, deals with mental illnesses, protects the poor, uplifts the downtrodden. In short he restores mankind to a state of harmony with itself, his neighbour and his environment. This is the mission of the church - a healing community.

The church not only has the motivation for holistic health care in the footsteps of its founder but it has the 'reach'. More than any other institution or organisation the church has the widest and deepest penetration of the community. And necessarily so because the mission of the church is to the individual, to the family, to the congregation and to the community, a community in which members care for each other. The congregation or the local church is to be found across the whole spectrum of humanity in the bright city lights in the slums along the highways and in the deep of jungles where no roads exist, each time a captive audience listening and raring to be sent ".....to preach and to have authority to drive out demons" (Mark 3: 14).

Way forward

The potential in the church congregations as an agent of change is enormous but often goes untapped. Our churches are, however, rising to the occasion and are mobilising, training, equipping and sending out health evangelists, village health helpers etc into homes, villages, market places, community schools, water wells, chief's *barazas*, anywhere humanity is found for the purposes of preaching the good news of salvations, teaching prevention of diseases through nutrition and good hygiene, maternal and child care, immunisations, treatment of common diseases, healthy family relations and any subject that will promote wholesomeness of the individual and the community.

But the church itself has some self searching to do. It has come a long way from the apostolic church which was a closely knit community of caring volunteers. Today, we see a church expanding, proclaiming, teaching, even pursuing establishment of institutions for development including health. Regrettably some of the mushrooming programmes and projects of grandiose have little touch with the realities of the bleeding villager. Wanted are strategies that will empower the community to take care of its own health.

In many national development plans and health policy documentation, there is only a fleeting reference to the contribution and potential of the CBHL church in healing and wholeness. Given that the community is not only the consumer but also the provider of holistic health care, the church congregations must be recognised as a primary vehicle of healing. A community is where people know each other by names and are bound by common values, needs and hopes. It is where they feel a sense of belonging of unity and trust that leads to caring for each other. The community is where a people share responsibility for the well-being of the neighbourhood. This may well be a description of the church congregation making it the dominant force at the community level. At this time of dire need for change towards *Health for All*, we ignore the church congregation at our own peril, for change and restoration is the mission of the church.

Rev. Michael Sande

The author is the Vicar of St Mark Church, Westlands, Nairobi

AIDS catch 22

from page 21

for their babies. The legislation against breast-feeding will therefore bring about endemic malnutrition among the infants, the health ministry fears.

Besides, the hide-and-seek game the virus plays with infants makes it even more difficult to effectively monitor the situation. Some babies are born HIV-positive but later turn negative, and for others the process is vice-versa.

Mothers certainly need all possible information and caring advice, even if the decision is ultimately left to them. The lives of innocent infants are at stake.

AANS

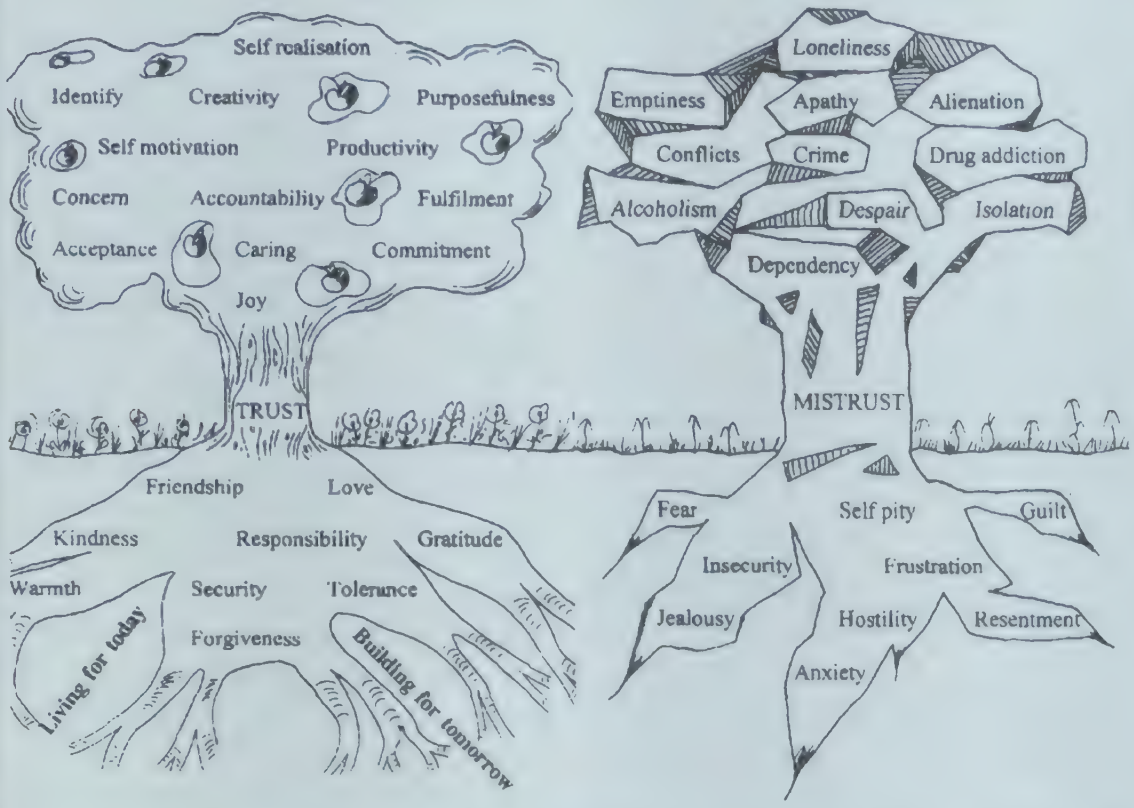
Passage to growth

from page 23

goal will consist of giving more functionality to the existing health structures and ensuring their sustainability in the frame of a renewed health system. This step will mark the passage from emergency to development. The challenge is great, but the ambition of the coordination team of the PTSHS II relies on the competences and the know–how of its members

P. Vata Diambanza s.j.
Expert journalist for the Delegation of The European Commission in Kinshasa.

The trees of mental health and illness



The pictures of the trees may show the concept of mental health and mental illness too much in terms of good or bad. In real life no line neatly divides the mentally healthy from the unhealthy. There are many different degrees of mental health.

Look at the pictures of the two trees. We are sure that nobody has the traits of good mental health all the time. We are just like Phila who is confident that she will learn from her experiences

Reprinted from Community Radio magazine – The PHC Connection, Cape town, South Africa

Can your baby hear you .....

Hearing impairments among children are difficult to detect, and may go unnoticed by parents or school health officials. An article published in the *Bulletin of the World Health Organisation* which reviewed screening for hearing impairment among children in developing countries notes that these impairments, "even when mild, may have a detrimental effect upon linguistic and evaluational development, which can result in social and psychological problems for affected children and their families."

Hearing impairments can be detected even in new-born infants. The following checklist gives simple and practical tests at different stages of a baby's first year of life.

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Parenting skills

By Wilfred Amalemba

Growing Together, a guide for parents and youth on sexuality was developed to stimulate parent and child interaction. However, some parents have found it necessary to get together as parents and study the parenting section together. One such group meets at St. Francis, CPK church, Nairobi.

Led by Dr. Peter Okaalet, a group of about ten adults gather together every Sunday, an hour before the morning worship service to have a family life Bible study. They have set aside one Sunday of every month to study *"Growing Together."*

They discuss the ideals presented with the realities that they are experiencing as modern day parents. Some of the issues that generate discussion among them is the difficulties in communicating with their children, the demand on time by other activities, denying one spare time for family, and the question of developing self-worth in children.

In one discussion, the parents covered the question of developing self-worth in children. They recalled their own experiences as youth and the challenges they faced. Said one parent, "I had four different images. What I was at home was different from who I was outside the home with my peers, at school and at church." The others nodded their appreciation. Another said, "I found myself in a similar situation and until I became a Christian, I didn't know there was a single standard to guide me in every situation, whether at home, at school or at the church."

The parents shared their experiences and learned from one another and from the book, lessons in parenting. One of the challenges that came out of the discussion was the need to come up with practical helps to deal with issues like how to make time for children. A mother said, "Much as I would like to spend time with my children, I find that there are other things competing for those few minutes I have in the evening. How can we be guided to make time for our children?"

Dakar meeting calls for pooling of resources

More than 250 delegates attended the two-day International Conference on partnerships between governments, NGOs and World Health Organisation held in Dakar, Senegal, in mid February.

The conference, convened at the initiative of Dr Ebrahim M. Samba who is the Regional Director of WHO for Africa in collaboration with the Government of Senegal, was attended by representatives of African Governments, national and international NGOs in Africa, Europe and America.

Dr. Dan Kaseje, the General Secretary of Afri-CAN, also attended. The meeting was attended by partners of Afri-CAN including the World Council of Churches, Panafrican Institute of Community Health, Zimbabwe Association of Christian Hospitals, Christian Health Association of Kenya, Lesotho, and Benin, the Christian Social Services Commission in Tanzania and the Lutheran Medical Services. The participants praised the initiatives of conference organisers which they said responded "to a need for concerted efforts, dialogue and collaboration."

The conference recognised that the actions undertaken in the African countries concerning health during the past decades, had a limited impact since, in spite of advances which have taken place, the global health situation of the populations remains a matter for concern - above all in rural areas.

Confronted with the magnitude of health problems in Africa, "we are conscious that no operator can alone obtain long-lasting results." The conference urged the partners who are governments, NGOs, WHO to instigate a social dialogue and to undertake action in a collaborative framework with the well-being of the most disinherited populations as a focus. It reaffirmed that the pooling of resources and of energies of all the operators will give more significant results than isolated action.

The conference further recognised the importance of the role that NGOs were asked to play in the implementation of health activities in the countries, and recommended to them to constitute groups at the national and international levels to make their contributions more efficient.

The delegates reaffirmed that the objectives of Health for All remain pertinent and that with the consolidated efforts of all partners, they can be obtained in the 21st Century.

The conference recommended to the Regional Director of WHO for Africa to pursue the ideas which have come out of the Dakar meeting with a view to defining, within a reasonable time, strategies for concerted efforts between the different partners in health, to guarantee an efficient and long-lasting partnership.

In this way, the methods for implementing an operational structure for co-ordination and for monitoring activities, in accordance with the spirit of the Dakar meeting, must be explored.

The conference asked the Minister for Health and Social Action in Senegal and the Regional Director of WHO for Africa to submit the recommendations of the Dakar Conference to the African Ministers for Health at the next meeting of the Regional Committee, planned for the month of September 1998 in Dakar.

The conference called upon all partners in health to associate themselves with the vast movement which has been born out of the Dakar meeting, and whose final objective is the implementation of collaborative and co-ordinated action in favour of the health of African Populations.

Seek cooperation and not competition says Janda

The General Secretary of All Africa Conference of Churches Rev. Canon Clement Janda called on NGOs in Africa to be committed to cooperation instead of competition among themselves.

"You are not traders who compete in business neither are our people you serve items for competition", he told a workshop on media production in Nairobi.

Rev Janda who was officially opening the workshop co–sponsored by Afri–CAN and Pharmaceutical Programme stressed " there is no sense behind competition but there is room and benefits from cooperation, networking and the need to support each other's endeavours."

He gave the assurance that during his tenure of service at AACC, he will ensure that the pan–African ecumenical body collaborates with other organisations which attempt to address "the problems of our communities". "We can all enhance each other's efforts", he added.

Expressing objections to World Bank/ IMF Structural Adjustment Programmes, he said SAPs should be scrapped, adding that World Bank/IMF were more pre–occupied with 'balancing' books irrespective of what it means to human beings.

The AACC chief noted that the African communities are largely hostages of the written word since "most African communities do not produce their own literature having lived with the oral culture for so long.

"The oral culture having served the primary purpose of preserving and conveying social values, the tendency now is to regard any written word as gospel truth", he added.

He went on 'our streets are however full of publications, but what do they communicate, can we say the literature around us is about life and light, can we say the same for advertisements?" he asked.

Advice to NGOs

from page 25

- Capacity to manage projects has been built among women.
- Entandikwa Scheme – thirty per cent goes to women.
- Poverty alleviation programme – sixty per cent goes to women.

Conclusion

NGOs should make an effort to work with Governments to complement what they are doing. Development processes impact differently on women and men and so do the dividends. Due to different effects, development projects and strategies should involve both men and women. The process also needs to be monitored and evaluated to guard against gender discrimination.

The writer is PHC co–ordinator, Uganda Protestant Medical Bureau, Kampala.

Ex-Norwegian premier set for WHO top post

FORMER Norwegian Prime Minister Gro Harlem Brundtland has been nominated for the post of Director-General of the World Health Organisation.

The 101st session of the Executive Board of the WHO meeting under the chairmanship of Dr Abdelhamid Aberkane passed a resolution effecting her nomination for the top WHO post last January.

This nomination will be submitted to the Fifty-first World Health Assembly, which will meet in Geneva from 11-16 May 1998. The new Director-General will take office on 21 July 1998.

Dr Brundtland was born on 20 April 1939 in Oslo, Norway. She studied medicine at the University of Oslo, from which she studied her M.D. degree in 1963. She received the degree of Master of Public Health from Harvard University in 1965.

From 1965 to 1967, Dr Brundtland served as medical officer at the Norwegian Directorate of Health. From 1968 to 1974, she was Assistant Medical Director at the Oslo Board of Health, Department of School Services. In 1974, Dr Brundtland was appointed Minister of Environment, a position she held for five years.

Appointed Prime Minister for the first time in 1981, Dr Brundtland held this position three times, the latest service from 1990 to October 1996. Altogether she was Head of Government for more than 10 years.

Among her numerous international positions, Dr Brundtland chaired, starting in 1983, the World Commission on Environment and Development, which coined the concept of "sustainable development" and made recommendations leading to the Earth Summit in Rio de Janeiro in 1992.

Dr Brundtland is married and is a mother of four and a grand-mother of seven.

Cost effective

from page 20

Possible exception

In case of patented drugs (for which there is no generic equivalent) the wholesale price of the nearest therapeutic equivalent could be taken as a reference.

12. Cost of international and local transport, warehousing, port clearance and appropriate storage and handling should be paid by the donor agency, unless specifically agreed otherwise with the recipient in advance.

Justification and explanation

This provision prevents the recipient from being forced to spend effort and money on the clearance and transport of unannounced consignments of unwanted items, and also enables the recipient to review the list of donated items at an early stage.

The article above is extracted from a MAY 1996 WORLD HEALTH ORGANISATION report entitled Guidelines for Drug Donations.

Collaboration between WHO and NGOs in the African region urged

Collaboration between the Word Health Organisation (WHO) and Non-governmental Organisations (NGOs), which is provided for in the organisation's constitution has gone through an evolutionary process over the last 50 years. In 1987, a framework to institutionalise the process of admitting NGOs into official relations with WHO was adopted and has formed the basis of such collaboration since. AFRO has, to date, established working relationships with NGOs mainly on ad hoc basis.

The key areas of collaboration include technical consultations, resource mobilisation, emergency and humanitarian assistance, health research and special health development initiatives. At country level, collaboration has been at the operational level and involving diverse health development programmes.

A need for defining a framework for the future collaboration between countries, NGOs and WHO was identified during an NGO forum organised by WHO in Geneva in May 1997.

The meeting with NGOs in Dakar defined specific priority areas of collaboration and principles and orientations for the collaboration. The meeting also set guidelines for developing appropriate networking mechanisms for collaboration between countries, NGOs and WHO in the African Region.

Happy Easter

Staff of Afri-CAN, CISS, Pharmaceutical Programme and the Working Committee of *Initiatives* wish all partners and *Initiatives* readers a Happy and rewarding Easter

"WHEN WE SAY THAT AIDS IS A CURSE, WE ARE SHIFTING BLAME AND DENYING RESPONSIBILITY"

AIDS — disease or curse, the debate continues

By Wilfred Amalemba

Those who are involved in AIDS control and prevention know the frustration of dealing with the "AIDS is a curse or God's judgment" belief. Such attitudes make efforts to control and prevent the spread of the epidemic harder.

People say that AIDS is a curse because it is incurable; it inflicts prolonged suffering and slowly eats away at its victim; it can wipe out an entire family; the person with AIDS must have done something considered taboo; its origin is unknown; its symptoms are similar to those of the diseases mentioned in Leviticus 26: 16 and Deuteronomy 28.

Belief often forms the basis of community and individual action. If, for example, one believes that AIDS is a curse of judgment, then one is likely to treat a person with AIDS without compassion. This can be seen in the cultural or biblical definitions of curses, bewitching and judgment.

A curse is defined as a pronouncement invoked against someone for rebelling against the society's norms. It can be passed on within the family, from one generation to the next. It is a persistent evil that has plagued someone or a family.

Bewitching is invoking evil spirits to attack or harm someone. Usually a disgruntled person who is envious of someone else consults a witch-doctor to cast a spell on his or her enemy.

Judgment is defined as a final decision or opinion of guilt or innocence passed by a judge for one's wrong-doing. Judgment can involve punishment, compensation and forgiveness. Its objective is to correct, teach, warn, or lead to repentance. Judgment can be lifted.

When AIDS is examined in relation to these definitions, it is evident that it may not necessarily be due to a curse, a judgment or bewitching.

AIDS can be transmitted to people unrelated to the HIV positive person, but a curse travels within one's family. Its cause is known - infection is through viral infection.

A curse's effects cannot be diagnosed medically, but AIDS can be diagnosed. Innocent people also suffer from it.

Biblically, God uses disease to glorify his name (John 9: 1-3) and Christ redeemed the world from the curse of the law (Galatians 3: 13).

AIDS also cannot be bewitching because witch-doctors have failed to eliminate the 'spell' cast upon their clients. There are several types of judgment defined in the bible. Universal judgment that is the result of sin. This one affects everyone - Romans 3: 23.

Cause-and-effect judgment that is based on natural law (e.g. law of gravity) and moral law (e.g. stealing results in punishment. Specific divine judgment that is God-ordained and happens outside the natural law (e.g. Sodom and Gomorrah). AIDS falls under the 'cause-and-effect' judgment. Irresponsible (or immoral) sexual behaviour may lead to HIV infection.

Turn to page 31

Culture and christian values

By Wilfred Amalemba

When caught in a dilemma between African traditional practice and Christian values, four families chose to keep the spirit rather than the letter of the tradition.

For ten days, some young boys stayed together, sharing food, having fun, and learning how to deal with the challenges of youth from a Christian angle. These were young initiates who shared in the ritual of circumcision as required by their tradition.

But their parents chose to circumcise the children in hospital and to give the accompanying lessons on life based on Christian values.

The children who shared the same cultural background, came from four devout Christian families living in Nairobi. "We decided to bring them together to facilitate the education programme instead of us shuttling from one house to another," says Mr. Aluvaala, one of the parents.

The programmes developed by these Christian parents, involved lessons on the significance of circumcision from a Christian viewpoint. Topics included obedience, discipline and self-control, peer pressure, the development of the body, relationships, career development, family and responsibilities, and the need for studying the Bible, prayer and fellowship.

The fathers used simple language and gave just enough information, particularly with the tough questions. "Don't under-rate children," says Mr. Busolo. "These ones had some tough questions, but we responded to them at their level and answered them as simply and fully as possible."

Since circumcision is a transition into manhood, the boys were given the Biblical perspective of true manhood. "We showed them that true manhood is not a show of physical strength but is being humble, obedient and disciplined," says Mr. Malea. "We told them that a more important circumcision is that which the Lord does on our hearts, when He changes us by His Spirit and transforms us (to be like Christ)."

The experience strengthened the relationship between these fathers and their sons. They became friends. The fathers assured their sons that they would always be available and accessible to them. "We became friends and told them that we were also their brothers," say Mr. Busolo.

Rather than surprise the boys as is done traditionally, these parents prepared their sons in advance. "It was better for them to be circumcised on familiar ground and amongst their peers."

Mr. Malea said that they also wanted to be aware of what their children were going through. In traditional circumcision, the children are taken away from the home to live in the forest through the initiation period. Parents are, therefore, ignorant of whatever happens there. Some of the activities the initiates undergo have spiritual significance and others are inconsistent with Christian values.

"Later on in life the children (who may have undergone the traditional way) may look back and say, 'My father didn't act like a Christian when he let me be circumcised traditionally,' says Mr. Busolo.

The choice that these families made met with some disapproval from their extended families. Some of their relatives objected to having the boys circumcised in hospitals and the deliberate avoidance of traditional rituals. But the families avoided quarrels by simply informing them of their decision and not discussing it further.

"We had to be consistent with our Christian convictions and be good models to our children," says Mr. Chengo, whose house was the learning centre. "We had to honour the promise made to God that we, the parents, would raise our children well and this means that we have to be responsible for our children." ❍

Disease or curse

from page 30

When we say that AIDS is a curse we are denying responsibility, shifting blame, justifying ourselves, being self-righteous, condemning or hiding our shame.

It is important for a counsellor to enable the person with AIDS to accept this condition and to take up positive steps to control and prevent further infection. Those who are HIV free are obliged to bring hope, reconciliation and restoration with God. ❍

Tips: What to know about your baby

from page 27

Can your baby hear you?*

Check if response is present.

Shortly after birth

Your baby should be startled by sudden loud noises such as a loud clap or a door slamming and should blink or open eyes widely to such sounds.

By one month

Your baby should be beginning to notice sudden prolonged sounds such as the noise of a vacuum cleaner and she should pause and listen to them when they begin.

By four months

She should quieten or smile to the sound of your voice even when she cannot see you. She may also turn her head or eyes towards you if you come up from behind and speak to her from the side.

By seven months

She should turn immediately to your voice across the room or to very quiet noises made on each side if she is not too occupied with other things.

By nine months

She should listen attentively to familiar everyday sounds and listen to very quiet noises made out of sight. She should also show pleasure in babbling loudly and tunefully.

By 12 months

She should show some response to her own name and to other familiar words. She may also respond when you say "no" and "bye-bye" even when she cannot see any accompanying person.

Reprinted from McCormick, B. Hearing "Screening by Health Visitors: A Critical Appraisal of the Distraction Test." **Health Visitor, 56, 449-451 (1983)*

A pharmaceutical programme with compassion

The economic crisis, adjustment programmes, population growth, have led to a decrease in purchasing power of many households in the world. At the same time, poverty with its associated malnutrition, poor living standards, poor hygiene and new and re-emerging diseases (AIDS, cholera, tuberculosis, childhood disease) make a heavy demand on health services and its resources. A decreasing ability of reluctance of the public sector to offe affordable health services has placed great burden on the not-for-profit organisations (such as churches and religious groups). There has been an increase in activities of the private for-profit sector but the high cost in this sector makes it an option beyond the reach on many. A decreased accessibility and affordability of essential drugs is one of the consequences of the above scenario.

The church health services which in many countries in Africa, is a major health care provider is thus faced with several challenges. Not only does it need to help make health care services accessible and affordable to even the least able in the society, but it must also induce the development and consolidation of health systems compatible with the local context. It is with these challenges in mind that the Pharmaceutical Programme was developed with a mission to facilitate the development of compassionate, just and sustainable health care in and through the church health care system. Its broad goals are:

- To guide and assist church-related health programmes and institutions to address, in a constructive manner, the issue of pharmaceuticals, through the implementation of EDC and RDU.
- To encourage, enable and/or represent the churches to be part of the movement for the promotion of just and equitable use of resources.

In order to achieve these goals, the programme is involved in four major areas of activity:

- Providing technical assistance through dissemination of information and support of visits by technical experts.
- Supporting training activities which centre on imparting skills and knowledge in the area of Essential Drugs Concept and Rational Drug Use.
- Supporting research aimed at monitoring and evaluating pharmaceutical activities so as to assist in identifying strengths, weaknesses and possible interventions.
- Offering a forum for networking on current trends and developments on pharmaceutical issues at local and global levels.

The pharmaceutical programme is an ecumenical undertaking which brings together Catholic and Protestant partners from North and South to jointly address a common issue. Since its inception until 1997, it was hosted by the World Council of Churches (WCC) in Geneva. The programme is now co-hosted by WCC and CISS and is physically located at the CISS offices in Nairobi, Kenya.

For further information on its activities and how one can be involved in its network, please contact:

The Director
Pharmaceutical Programme
P. O. Box 73860
Nairobi, Kenya.
Tel: 729095
Fax: 711918.

Small grants for pharmaceutical projects

Are you planning an operational research project in good pharmaceutical practice? The joint World Council of Churches (WCC)/Community Initiatives Support Services (CISS) is offering small grants to support churches, church-related health institutions, agencies and groups involved in assessing, monitoring and evaluating church pharmaceutical activities. The funds available are only for specific operational research projects and will not be available for capital expenditure, e.g. purchase of land, property, vehicles or equipment, nor for salaries other than those directly related to the research.

Projects/ research given priority include those which aim to:

1. Raise awareness of the essential drugs concept (EDC) and rational drug use (RDU), including effective drug management; or increase understanding of the effects of global policies on EDC and RDU.
2. Change behaviour e.g. in terms of prescribing habits, dispensing habits, drug management; or which demystify drugs and medical care; or which change attitudes towards drugs.
3. Promote an understanding of health beyond that of drugs, such as initiatives in support of the involvement of churches and communities in health and healing. (This might include initiatives in the promotion of traditional methods of healing).
4. Find innovative ways to sustain health care, minimize health costs and promote self reliance.

For more information, please contact: Dr Eva Ombaka, Director, WCC/CISS Pharmaceutical Programme,
P. O. Box 73860, Nairobi, Kenya.
Tel: 254 2 729095/725003. Fax: 254 2 711918.

CISS Institute

Community Initiatives Support Services International – CISS – has been working on an exciting project to develop the Tropical Institute of Community Health and Development in Africa. The institute will open formally on 21st May 1998 and will offer courses leading to recognised certificates and post graduate degrees and diplomas. The main objective of the courses is to strengthen people in management and leadership roles in integrated Community Health and Development Programmes with a major focus in utilising capacities and resources of the community in innovative programme development and management.

All enquiries to
The Director,
Tropical Institute of Community Health and Development in Africa (TICH)
P.O. Box 73860,
Nairobi, Kenya.

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